

1284 PHM/SR9-54 (234)

# Challenges for Health as a Social Movement: Lessons from the Jan Swasthya Abhiyan experience at National and State levels in India

Findings of the Participatory Assessment for Network Strengthening process of JSA (PANS) based on a compilation of Organizational /networks responses to the PANS questionnaire and reports of state level process and meetings.

Facilitated and compiled by :

SOCHARA Team: Ravi Narayan/ Venkatesan.R

JSA Support Committee: Amit Sengupta/ Mira Shiva/ Sarojini/  
Joe Varghese/ Sulakshana Nandi

15<sup>th</sup> May 2012

SECTION – 4







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## Section: 4

### Source documents:

#### List of Items:

1. Towards a learning exercise- Review and Social audit of JSA: A participatory dialogue (E-mail communications)
2. Facilitating team, JSA –PANS. “Towards a Participatory Assessment for Network Strengthening of JSA(PANS)” 12<sup>th</sup> July 2010
3. Anant Phadke, JAA- Maharashtra. “ Self review process in Jan Aarogya Abhiyan in Maharashtra”
4. Akila Vasan and E.Premdas, JAAK- Karnataka. “ Jana Arogya Andolana Karnataka (JAAK) Participatory Assessment for Network Strengthening (PANS) compiled Report
5. Facilitation team, MNI- Tamil Nadu. “Minutes of the meeting dated 24<sup>th</sup> October, 2011”
6. Facilitation team, JSA- Odisha. “ Report of the state level participatory Assessment and Network strengthening meeting of JSA, Odisha dated 29<sup>th</sup> October, 2011”
7. Facilitators, JSA- Madhya Pradesh. “ Brief report of MP-JSA meeting held on 2011”
8. Facilitators, JSA- Uttar Pradesh. “Summary of Power point presented on JSA-NCC meeting 10<sup>th</sup> to 12<sup>th</sup> of November, Nagpur “
9. Facilitators, JSA- Delhi. “ Jan Swasthya Abhiyan (JSAD): Brief Update( 2010-2011)”
10. Facilitators, JSA- Rajasthan. “ Self Review Report of Jan Swasthya Abhiyan, Rajasthan”
11. Facilitators, JSA-Gujarat. “ Minutes of JSA meeting at Jhagadia, 26<sup>th</sup> and 27<sup>th</sup> Sept.2011”
12. Facilitators, JSA- Chattisgarh. “ Chattisgarh Jan Swasthya Abhiyan state level meeting, 8<sup>th</sup> November, Raipur”
13. Sarojini and Deepa, SAMA- Resource Group for Women and Health. JSA-PANS (participatory Assessment of Network Strengthening) 9<sup>th</sup> October 2011
14. Facilitators, All India Drug Action Network (AIDAN). JSA-PANS (Participatory Assessment for Network Strengthening)
15. Facilitators, Health Watch Forum. JSA-PANS (Participatory Assessment of Network Strengthening)
16. Facilitators, Breastfeeding Promotion Network of India (BPNI). JSA-PANS (Participatory Assessment of Network Strengthening) 17<sup>th</sup> October, 2011
17. Thelma Narayan, Society for Community Health Awareness, research and Action (SOCHARA). JSA-PANS ( Participatory Assessment of Network Strengthening) 10<sup>th</sup> November, 2011







18. Facilitators, All India Democratic Women's Association (AIDWA).JSA-PANS ( Participatory Assessment of Network Strengthening)
19. Sundar Bunga, Catholic Health Association of India (CHAI). JSA-PANS (Participatory Assessment of Network Strengthening) 17<sup>th</sup> October 2011
20. Radha Krishnan, KSSP. JSA-PANS (Participatory Assessment of Network Strengthening)
21. Renu, JAA-Maharashtra. " Jana Aarogya Abhiyan, Pune ,Maharashtra"
22. Sarojini, Odisha. "The Orissa PANS meeting"
- ✓23. People's Charter for Health ( 8th December 2000) ~Global
- ✓24. Indian People's Health Charter ( November 2000)
25. People's Health Movement, India: Jan Swasthya Abhiyan (JSA) "Appendix 10 of the Global Evaluation Report of the PHM"
26. Ravi Narayan, SOCHARA. " Some reflections and observations on JSA/PHM from Non PHM Sources-presented at JSA NCC meeting 10<sup>th</sup> to 12<sup>th</sup> of November, Nagpur
27. Summary of the PANS process-presented at JSA NCC meeting 10<sup>th</sup> to 12<sup>th</sup> of November, Nagpur
28. Facilitating team, PANS questionnaire for NCC, 28<sup>th</sup> September 2011







## Towards a learning exercise- Review and social audit of JSA 2000-2009/E-Mail Communications:

Date: Oct 30, 2009 (Ravi)

As you gather for the next meeting of the NCC of the JSA, this is to share an idea of a review of JSA which I have suggested earlier. I believe as we reach the 10<sup>th</sup> year of JSA in 2010 we should organise a series learning exercise on the experience of the last decade. We have all contributed greatly to an emerging collective approach to various initiatives of JSA. These have included state and national assemblies, jan sunwais, campaigns, publications, policy briefs, letters and submissions to government, debates, dialogue with NRHM & WHO CSDH and so many state level activities as well.

The website and the e-groups have been good developments but they could be strengthened further in process and content as part of the learning exercise. Access to all the JSA/state level documentation/publication is still a challenge. Our community health library and information centre (CLIC) has a good collection but even that is probably incomplete.

Organizationally, while at national level there has been a constant dialogue and a collective decision making process, the experience at state levels is very varied. It ranges from very good networking in some states to rather poor and non inclusive efforts in others. However most of this assessment is anecdotal or the opinion of some individuals.

The important issue is are we growing as a movement – as a network promoting Health for All in India? Can we do better? If we are dissatisfied with the situation what are the factors to address? How do we bring back and sustain the enormous solidarity of Kolkatta assembly and the Savar-PHAI and the surges of energy at Cuenca and Bhopal? These could be some of the goals of the learning exercises.

We have moved from the politics of confrontation to the politics of engagement? How successful have we been? Are we documenting our strategies? Are we reviewing them from time to time? Academics all over the world not linked to the movement but following it, have described PHM “ **as globalizing health solidarity from below to counter the ill effects of globalization of health from above**” How much of our initiatives have been ‘top down’ ? or ‘bottom up’ ?

I am sure there are many more questions than answers but I do feel we have the collective maturity and experience to start a process. Andrew Chetley did a similar exercise of reviewing PHM in 2004 which was good learning experience and is available on the global PHM website.

After the next CoCo meeting in Havana in November, I will have more time to write, facilitate and review and would be willing to initiate an interactive participatory learning process on the matters shared above, if the NCC agrees and endorses it as a good idea. The process of review or social audit can itself emerge through an interactive exercise. Having been relatively aloof from JSA because of PHM global responsibilities I may be able to add an element of objectivity to the review process. There are other demands on my time but I would like to offer to refocuss on







learning from the PHM India experience, which has been both an inspiration and a collective opportunity.

**Date:** Dec 13, 2009 (Abhay)

### **Should we have an internal, participatory review to strengthen JSA?**

In the recent JSA NCC meeting at Delhi on 5<sup>th</sup> Nov., Ravi Narayan's suggestion of conducting an internal review of JSA, related to completing ten years of JSA in 2010, was discussed. While some of us supported the idea in certain form, there was surprisingly considerable resistance from certain senior JSA organisers belonging to a particular network.

It was argued that we 'do not need an evaluation since that is only done by NGOs / large institutions, while we are a network'; it was claimed that 'we are being evaluated by the public everyday' so there is no need for such review; that 'we anyway have a review of activities in every NCC meeting' and that 'an evaluation could be disruptive'. After some discussion there was no consensus, and it was reluctantly agreed that this issue needs further discussion and that there could be a 'full day session on organisational issues' in the next NCC meeting.

This discussion was simultaneously dismaying and enlightening for me. Dismaying because I cannot comprehend why certain JSA organizers should have so much resistance to a participatory process for understanding the gaps and strengthening the JSA network. Enlightening because I came to understand that perhaps there are significantly differing perceptions within JSA, about the current state of the network's organisation and whether something needs to be done to address this situation. Apparently, while some of us feel that there are significant organizational issues concerning JSA esp. in certain states, others probably feel that these issues are insignificant, or at least do not merit a process like a review.

In this situation, we need to ask – is JSA regularly growing and expanding nationally as a network? Is the JSA coalition in all states sufficiently inclusive, with coordination being shared by diverse groups? Are all state coalitions developing campaign activities in a sustained and reasonably broad based manner? Are constituent networks and organisations adopting a broader JSA identity, to some extent transcending their particular organizational identities, with genuinely shared decision making, as is necessary for a healthy network to develop? If the answer to all these is **yes**, then we should celebrate 10 years of JSA next year and there may not be much need for an internal review or similar organizational reflection. However, if the answer is even a tentative **perhaps no or not enough**, then there is serious need for reflection, debate and organizational measures to ensure that the JSA network achieves its potential as a broad based and genuinely democratic campaign coalition, in the spirit in which it was founded a decade back in the year 2000.

I am presently circulating this mail to only a few JSA activists, to get a sense of whether there is a basic critical mass within JSA that is interested in such a review process. If such a critical mass in favour of a review exists, then of course the issues concerning a review and the detailed suggestions about methodology must be later shared and actively debated in the entire JSA network in a healthy, open and democratic spirit. However, if there is no such critical mass, then those of us who are suggesting this process should reconsider whether we should think about such a review.







In my view such a participatory review process, oriented to broadening and strengthening JSA is not an end in itself, but would *create conditions conducive to wider campaign development in the coming period – say for a ‘Right to Health – Universal access to Health care’ campaign*. Given rapid development of privatisation oriented PPPs, large scale violation of rights in the private sector as well as continued inadequacy of the public health system, and the lack of political will around the National Health Bill, there is urgent need for a larger campaign on Health rights.

In a positive scenario, there could be a ‘virtuous cycle’ - organisational broadening would increase our campaign effectiveness, while developing a broad based campaign would further strengthen and rejuvenate the network. It will also be worthwhile to learn specific lessons from state JSA units which have managed to broaden the network and effectively carry out collective activities.

Keeping this background in mind, I would suggest that we could first have a round of exchange about this among ourselves and share our perceptions and suggestions. For example, we could circulate our views about the following questions:

- a. How do we organizationally assess JSA in our own state? Would it be useful to have an organisation strengthening oriented review of JSA in our state?
- b. Based on our experience of working in JSA nationally, are we satisfied that the network in various other states is generally broad based and working with shared coordination and decision making?
- c. If not, do we think that some process like an internal review / reflection, maybe starting in a few states which have interested organisers, would be useful to understand the issues and gaps, with a view to overcoming these and strengthening JSA?
- d. If we think a review / organizational reflection would be useful, in our opinion what should be the form and process for this? Could this be facilitated by some senior JSA related persons coming from outside each state?

I would specifically urge Ravi to circulate his suggestions about the review process since he has given some thought to this, and probably has certain methodology in mind.

If there is agreement that we can have such a review at least in a few states to begin with, then one suggestion is that we could have a small meeting of some JSA activists in Feb. / March to discuss this in detail.

It should be emphasised that the sole purpose of such an exercise should be to strengthen and rejuvenate JSA, and not to create any kind of divisiveness. However, if there are problems in a network then closing our eyes to these, or sweeping them under the carpet will not help. In certain situations some JSA activists may need to take the lead to develop positive processes for the health of the larger network, provided that this is done in a democratic manner and with positive intentions.

Based on responses from all, we could consider how to further look at this process and take things forward.

**Date:** Dec 14, 2009 (Renu)

I think that we should do an internal reflection in JSA from the perspective of strengthening it. And we







should do this with whoever/ whichever state is ready. I can propose it in Gujarat.... After our initial discussions and the internal reflection amongst ourselves, we can decide the modalities and who can be the facilitating team.

Let us keep the discussions going without innuendos, maintaining a constructive stance, evoking people's good sense and positivity rather than driving people into corners/against the wall, or creating possible factions. So good luck to all of us and I hope others respond and we can work something out.

**Date:** Dec 15, 2009 (Amulya)

Abhay thanks for again raising this issue as we all are aware that in last Bhopal Health assembly review of JSA was proposed but it was postponed or i would say may be cancelled for time being. From last 2-3 years we were trying to raise issues in M.P state level meetings and also in one of the NCC in Mumbai that there is an organisational issues which needs to be discussed in detail in a way to strengthen it. There are issues of funding, decision making process and 2nd level leadership and off course approach in taking up the issues. In M.P as we had prepared a separate report of NRHM watch and Taking action in Corruption issues due to gap in our approach in that particular activities and there are more.

I feel that Madhya Pradesh too in continuation of Gujrat require review of JSA activities and more detailed discussion about how to strengthen JSA.

**Date:** Dec 15, 2009 (Rakhal)

The JSA has evolved into a very precious forum (i use the word after much thought). Not only is it one of the few fora / network taking up health issues from a people's point of view, but it has greatly gained in credibility at various levels (and i don't mean only within the government).

It is fairly obvious that there is need to widen and deepen this network. However individual networks (who compose the JSA) obviously have different ways of functioning, different zones of comfort etc. etc. it is crucial to work towards a common minimum and to constantly refine and further this minimum - step by step.

There are deep differences within JSA.... Nandigram threw some up, the recent discussion on the National Health bill was very healthy, the need for a review of JSA also shows up some differences. While Abhay's note was specifically referring to one network (BGVS) I am equally concerned about NAPM, PWN+, and many other dalit and women's networks whom we haven't yet got on board, or got on board but not necessarily reflecting their presence in our work(JSA) / perspectives. There is also urgent need to discuss how to deal with these differences....

Of course all of us in our individual capacities are working closely with these and many other groups (including BGVS) but the question is at a national level are all views being reflected.... why not? How do we strengthen this mechanism?







And with regards to Abhays' choice of circulating this mail... I see nothing inappropriate in an initial mail to group of people who are deeply concerned about JSA to gather consensus before taking any steps. Yes we need to broaden the consensus...

yes we need to democratize.... and i suggest that apart from taking up Anant's suggestion of undertaking state level reviews I also suggest that the review process includes trying to understand the perspectives of all of our present and former constituents... why are they with us? why have they left us? why are they inactive? Also how many groups are joining up the JSA especially at the state level? why? why not?

Even as one by one all democratic forms and spaces of dissent and alternatives are being closed (and becoming confusing)... I am sure all of you have been following the events of Narayanpatna and of the build up to the padayatra..... Which are happening at the same time as many of us are taking part in the mid term appraisal of the XIth five year plan, there is urgent need to strengthen this forum / space.

**Date:** Dec 16, 2009 (Anand Phadke)

I am in favour of a self-review of JSA. But I think, let us first have such a review in Jan Aarogya Abhiyan in Maharashtra and in say JSA Karnataka. Based on this experience, the all India JSA review can be suggested. I think, the sectarian, stupid, manipulative attitude of some people in JSA is only part of the problem. There are deeper problems. Hence JSA has declined also in areas where such people do not have much influence. Let us discover the causes and remedies for this deeper problem, have a programme for re-energising JSA in various states, mainly through local campaigns and as part of this larger initiative, deal with these unhealthy tendencies. Pushing the idea at an all India level of JSA-review would merely bring into open the schism in JSA, affect whatever solidarity that now exists without any chance of any positive outcome in absence of some alternative that has been tried successfully at local level. To revive the moribund JSA, we need to first work at local level, where BGVS's unhealthy influence is marginal, to solve the deeper problems.

**Date:** Dec 17, 2009 (Indira)

A review of JSA is long overdue, and it is good that this issue has been (re)opened. As Amulya has pointed out, it was (conveniently) cancelled at the II NHA in Bhopal, with no explanations given. It is unhealthy, to say the least, that a network functions for nearly ten years with the same set of functionaries, does not feel the need to assess its role/contribution, etc.

While I broadly agree with what has been shared so far by the others, however, I find the somewhat 'apologetic' stance a bit uncomfortable. I may be pardoned for saying this – but I get the feeling that







the concern seems to be to not to 'disturb' the network in this process of review. I only hope I am wrong on this. If there are differences/schisms then they need to be accepted and confronted, and only then one can work towards a positive role for JSA, or whatever formation emerges subsequently. It is difficult to work under the present circumstances, as the PRHW experience indicated to me.

Secondly, regarding beginning with state reviews – it is a good suggestion. However, we need to keep in mind that the JSA is a broad network possibly in only TN, Maharashtra, Karnataka and Gujarat. My experience of PRHW in the northern states has been rather disappointing – in UP-Bihar-HP-Uttaranchal there is no network. It is just BGVS; there is almost no network in Jharkhand; I am not sure about Orissa now, but there also there was no coherent network. By this I mean that there are no organized networks in all these states that are functioning in the consistent manner in which, say JAA in Maharashtra works. I had pointed this out a few times in some personal discussions with Rakhal-Abhay-Amulya. So what will a review mean here? We need to keep this in mind when we talk of "review of state JSA".

Thirdly, I am sure a review would include assessment of what are considered as the "achievements" of the JSA. Which means that we need to have an understanding of how we view contemporary developments in public health. While there may be a somewhat common understanding on the so-called social determinants of health, I feel there are differences regarding health policies, health services and their provision, medical care, NRHM, the so-called 'new management practices', role of NGOs, etc. I think these should be stated and confronted. One thing that has always bothered me is – Is it possible (and desirable) to have a so-called 'common vision or common platform', given the deep ideological differences within and the heterogeneity of the network? What is considered a 'strength' or positive feature could actually be a major limitation in terms of how we address the issues that are coming.

With best wishes to all of us in this process, and looking forward to a productive, critical, meaningful review.

**Date:** Dec 18 (Ravi)

Just to acknowledge receipt of all the dialogue on the idea of the JSA learning review that I had recently suggested to the jsa-ncc. I am glad it has provoked a lot of collective energy and interest. I have been rather busy with some commitments hence was waiting for this next weekend to respond to all your suggestions and concerns and add some methodological and process clarity to the ongoing dialogue. I was also waiting for a first response from all who got the initial communication from Abhay, since as a process everyone should share a first gut level response before we build the next step of the process. So anyone who has not yet responded please do.







(2) JSA:- PANS (background & methodology)

## Towards a Participatory Assessment for Network Strengthening of JSA (PANS)

### Section-I

#### Introduction and background

##### 1. The Idea :

A communication from a past joint convener of JSA (RN) to the NCC meeting in November 2009 at New Delhi suggested a learning exercise on the JSA experience over the last decade 2000-2010. This communication made the following suggestions.

- a) The need to learn from various initiatives of JSA that have included state and national assemblies, Jan Sunwais, campaigns, publications, policy briefs, letters and submission to government, debates, dialogue with NRHM and WHO-CSDH and so many state level activities as well.
- b) The assessment of the website and the e-group communications as processes to strengthen the networking
- c) Increasing the access to all the JSA/State level documentation/publications which remains a challenge. (The SOCHARA library - CLIC in Bangalore has a good collection but even that is probably incomplete)
- d) The need to assess the constant dialogue and collective decision making process, at National and State levels recognizing that this has ranged from very good networking at national and some states to rather inadequate efforts in others. However most of this assessment so far has been anecdotal or the opinion of some individuals and hence the need for a more planned review.

In the same communication some questions were also raised.

- i) Are we growing as a movement or network promoting Health For All in India? Can we do better?
- ii) If we are dissatisfied with the situation (at the national or state levels) what are the factors to address?
- iii) How do we bring back and sustain the enormous solidarity of the Kolkatta assembly and the Savar - PHA and the surges of energy after the assemblies in Mumbai, Cuenca and Bhopal?
- iv) We have moved from the 'Politics of confrontation' to the "politics of engagement"? How successful have we been? Are we documenting our strategies? Are we reviewing them from time to time?
- v) Academics all over the world, not linked to the movement, have described PHM- "as globalizing health solidarity from below to counter the ill effects of globalization of health from above". How much of our initiatives have been top down? or bottom up?

Finally the communication also noted that this learning process could be participatory and interactive and the review emerging from it would be like a social audit of the JSA, by JSA constituents/members themselves. Since the experience of PHM -India (JSA) has been an inspiration to many people and countries in the global network, this exercise would also be collective learning opportunity.

##### 2. Dialogue around the idea:

During the months of November – December 2009, many JSA members wrote to RN and while endorsing the overall idea made some additional suggestions and provided more questions as well. These included the following:

- i) Is JSA growing and expanding nationally as a network?
- ii) Is the JSA coalition in all states sufficiently inclusive with coordination being shared by diverse groups?
- iii) Are all states coalitions developing campaign activities in a sustained and reasonably broad based manner?







- iv) Are constituent networks and organizations adopting a broader JSA identity to some extent transcending their particular organization identities with genuinely shared decision making?
- v) Can the participatory review process oriented to broadening and strengthening JSA not become an end in itself but also create conditions conducive to wider campaign development in the coming periods for a Right to Health – Universal access to Health Care Campaign.?
- vi) Can we learn specific lessons from state JSA units which have managed to broaden the network and effectively carry out collective activities and therefore increase campaign effectiveness?
- vii) How do we organizationally assess JSA in every state? How do we build further on the strengths in each state and tackle the weaknesses if any?
- viii) Is it necessary to have a national review and or state reviews?
- ix) What form and process should this organizational reflection/review adopt? Could senior JSA related persons from other states support each state review process?
- x) Can the exercise strengthen and rejuvenate JSA at every level and not create any kind of divisiveness? Can the problems identified be dealt through positive processes that enhance the democratic character of the process?
- xi) Can the internal reflections in JSA for the purpose of strengthening be done through discussion without innuendos, maintaining a constructive stance, evoking people's good sense positively rather than creating possible factions?
- xii) Can the review tackle organizational issues like funding, decision making process, second level leadership, approach while taking up issues and campaigns in details to strengthen the processes further ?
- xiii) Can the review widen and deepen the network and work towards a common minimum programme and further refine this programme step by step learning from the credibility developed at national and some state levels?
- xiv) Many networks that were active in the beginning are not fully on board now a days or are on board, but their perspectives and concerns are not fully reflected in our work. How do we tackle this as well deal with our differences?
- xv) Can the review process also try to understand the perspective of all our present and former constituents? Why are they with us? Why have they left us? Why are they inactive?
- xvi) How many groups are joining the JSA especially at state level? why? Why not?
- xvii) Many of us are taking part in mid term appraisal of the XI five year plan, others are involved with NRHM in many ways including community monitoring in some states. How do we urgently strengthen the potential for engagement in the few fora and spaces remaining for democratic dissent and dialogue through the JSA?
- xviii) Could we discover the causes and remedies for the challenges at state level so that JSA can be re-energised at state levels before moving to the national level where the experience till recently has been fairly positive?
- xix) Could we undertake the review in a spirit of learning without feeling apologetic or uncomfortable with the process even if there are differences of opinion since these need to be tackled in a positive way rather than ignore to strengthen the JSA formation further?
- xx) Since the level of organization at state level is very heterogenous what a review means in each state may be very different. Can we keep this diversity and plurality in mind?
- xxi) While we may have a common understanding of the social determinant of health there are difference regarding health policies, health services and their provision, medical care, NRHM management practices, role of NGO's etc. Can the review identify, some of these perspective difference so that we could dialogue to build some consensus wherever possible?
- xxii) Is there a common vision or a common platform given the ideological heterogeneity of the network? Can the review identify this common vision and further underline it?
- xxiii) Can we take stock of not only our strengths /achievements/ outputs and also look at the drawbacks /setbacks and failures if any so that action to address them may be taken?





### 3. Participatory Assessment for Network Strengthening (PANS) A JSA- NCC initiative:

In February 21<sup>st</sup>, 2010, the JSA –NCC finally discussed the review and all the ideas and suggestions that the participants provided at that meeting and an exercise called PANS- ‘Participatory Assessment for Network Strengthening’ of the Jana Swasthya Abhiyan was finalized with the following guidelines:

- a. The purpose of the exercise is to strengthen the JSA as a movement and to conduct an assessment that is participatory in nature.
- b. The exercise recognizes that the JSA is comprised of organization and networks who have voluntarily come together and who carry with them diverse experiences and methods of functioning. While being sensitive to this variegated nature of the network, the exercise will be limited to ‘JSA as a whole’ and not extend to ‘individual partner organizations’.
- c. For the exercise to be sensitive to the character of the JSA as well as to capture the varied nuances in the JSA, it will be led by people who have been active in the JSA. It is thus not an ‘external evaluation’ or even an internal evaluation done by external consultants.
- d. JSA has no methodology or intent of compelling individual partners or state JSA to participate in the present process which is a voluntary exercise and not an intrusion. Those who do not wish to be part of the process are free to express the same with full freedom
- e. In order to add value to the process, it would be useful for senior activists external to each state JSA to be part of the exercise in individual state JSA’s. The state JSA’s have the option of suggesting (1 or 2 senior activists) who could be invited to their state assessment processes.
- f. All state JSA’s are encouraged to set up adequate time in an inclusive meeting to carry out the assessment.
- g. All state JSA’s will be encouraged to share with network organizations a brief document/questionnaire that details the purpose of the assessment and as important questions from partners regarding JSA ability to function as an inclusive movement.
- h. A similar exercise will be conducted at National level based also on a brief document /questionnaire.
- i. A small team to coordinate the process has been formed at the NCC meeting in Kolkatta in Feb 2010, which includes Renu Khanna, Sulakshana Nandi, Mira Shiva, Ravi Narayan, and Amit Sengupta.
- j. To evolve the methodology for assessment the following framework of areas of assessment for inclusion were identified.

Frame work for Participatory Arrangement for Movement Strengthening (PANS)

#### 1) Co-ordination between Network partners and functioning of Secretariat and NCC

- Dissemination of information and clearing house functions
- Transparency and Participation in decision making
- Response to current issues of importance
- Methodology to arrive at common positions
- Co-ordinated programmes
- Co-ordination with Global PHM
- Co-ordination with other movements





- Representation of JSA's position in engagement with Government
- Inclusion of new partners

## 2) Strengthening of State JSAs

- Capacity (human and other resources) to engage with major issues and undertake independent activities
- Inclusive nature of state process – range of partners, transparency in decision making process
- Regularity of functioning
- Response to state level issues
- Co-ordination with national secretariat.

## 3) Situation analysis of state health context and JSA

This should be described in the context of the challenges/ demands included in the Indian People's Health Charter and the report on JSA should include the key developments in the state in the period 2000 to 2010. It may include:

- Membership and networking (organizational structure)
- Events
- Publications
- Campaigns/ initiatives
- Public hearings/Jan Sunvais
- Engagement with state in any way
- Any other significant involvement /linkage.

## Section- II

### The context and Frame work of Assessment

Some important historical details, organizational objectives and evolving framework of action drawn from the handouts of the JSA and the Indian People Health Charter, particularly from the People's Health Source Book, published in 2004 are enumerated here as background and context for reference for all those at State and National levels involved with evolving PANS project.

1. The Jana Swasthya Abhiyan (PHM India) evolved through a dialogue process that began in November 1999, at the Bangalore dialogue of the International Poverty and Health Network ( where members of the organizing committee of the Global People's Health Assembly- including Dr. Zafarullah Chowdhury, Dr. Qasem Chowdhury, Prof. Mathura Shrestha, Dr. Prem John, Dr. Mira Shiva and Dr. Mohan Rao met some public health activists including Prof. D. Banerjee, Dr. B. Ekbal, Dr. Ravi Narayan, Dr. Thelma Narayan, and others to discuss the Indian mobilization for the proposed global People's Health Assembly in Savar, Bangladesh, (Scheduled for December 2000) The statement of the IPHN dialogue which was widely circulated had many elements of the global charter that evolved in 2000AD.

2. Three organizations began to work closely together to evolve a national mobilization response to the proposed PHA. This included the All India People's Science Network,( Dr. Sundararaman, Pondicherry Science Forum and Balaji Sampath of the Tamilnadu Science Forum) and Society for Community Health Awareness, Research and Action, Bangalore ( represented by Dr. Ravi Narayan)

3. In January 2000, at a meeting in Chennai, a decision to bring together 18 National Networks of Voluntary organizations to organise a campaign with the slogan Health for All, Now was made and





a plan of mobilization towards a people's health assembly in India before the Global assembly in Savar was initiated.

4. These 18 networks included two science movement related ( AIPSN and BGVS); the National Alliance of Peoples Movement (NAPM); several health related networks ( mfc, VHAI, CHAI, CMAI, AIDAN, ACHAN, SOCHARA); four networks related to the women's movement ( AIDWA, JWP, NFIW, NAWO) and four others ( FORCES, FMRAI, AID-India and the Ramakrishna Mission ).

5. As part of the campaign, 5 cartoon books on five broad themes (What Globalisation does to People's Health; Whatever happened to Health for ALL by 2000AD; Making life worth living; A world where we matter; and Confronting commercialization of Health Care) were evolved through contributions by number of authors to different subsections, which was finally ratified by representatives of 18 national networks in Hyderabad, in April 2000 at a five day workshop in which the draft booklets were considered page by page. For the first time in the country such a wide range of organizations came together to produce these five booklets as a symbol of an emerging consciousness towards the challenges for Health for All.

6. These books were translated into languages – Hindi, Tamil, Kannada, Marathi, Malayalam, Telugu, Bengali, Gujarati, Oriya and copies sold/distributed to health professionals activists and people interested in health issues. Halfdan Mahler the former Director General of WHO and the architect of the Alma Ata Declaration described these books as **'the best expressions of the primary health care concept and its politics that I have ever read. They are the bible of Primary Health Care, a glorious milestone on the tortuous road to primary health care'**.

7. Between April - November 2000, the books supported a campaign of public education and mobilization that included village, district, and state level meetings; village based enquires; kalajatha adaptations of the main messages in some states; and dialogue with professionals, health activists and providers / policy makers in the existing health services.

8. After a series of State health assemblies in nearly 17 states (Andhra , Assam, Bihar, Delhi, Gujarat, Haryana, Himchal Pradesh, Jharkhand, Karnataka, Kerala, Maharastra, Orissa, Punjab, Rajasthan, Tamilnadu, Tripura, UP) around 2500 health professionals and activists in 4 peoples health trains, assembled at Kolkatta for the first National Health Assembly (Jan Swasthya Sabha) from 29<sup>th</sup> Nov till 2<sup>nd</sup> Dec 2000.

9. An Indian People's Health Charter was adopted at the end of the Assembly and announced at the end of the Assembly, after a march through the streets of Kolkatta. At a rally in the maidan, under the inspiring leadership of Dr. Lakshmi Sehgal (the head of the Rani Jhansi regiment of the INA) a Health for All, now campaign was launched as the second national struggle for independence from ill health and illiteracy

10. The Indian People's Health Charter is an important reference point for this exercise since it lays out the objectives and the demands of the Health for All, Now campaign. It can become the reference points to review our efforts at state level and also at national level. Ultimately our learning review has to help us assess at state and national level, not only what we have done and how, but also where have we reached /not reached in each state and national level vis a vis these goals and demands.

11. The Indian People's Health Charter can be summarized as follows

- a) **We declare Health as a justiciable right and demand the provision of comprehensive health care as a fundamental constitutional right of everyone of us with seven basic concepts.**





- Decentralized local governance
- Sustainable agricultural and a decentralized PDS
- Universal access to education, water housing and sanitation facility
- Dignified and sustainable environment
- Clean and sustainable environment
- Drug industry producing epidemiologically essential drugs at affordable cost.
- Health care system that is gender sensitive and responsive to peoples need and not the markets.

**b) We oppose**

- Market oriented agricultural policies.
- Appropriation of natural resources livelihood and biodiversity for private profit.
- Conversion of health into mere technology intensive, expensive, and inaccessible,
- medical care for select few, reduction of public sector expenditure on medical care and introduction of user fees in public sector institution.
- Corporatization of medical care and corporate sector health insurance
- Coercive population control and promotion of hazardous contraceptives technology
- Patent regimes that put medical technology and drugs beyond the reach of many.
- Institutionalization of fundamentalism, caste, patriarchy and violence in our society.

**c) We demand**

1. Comprehensive Primary Health Care – integrates decentralization and with commitments
2. Primary health care under PRI's participation and village level health workers and Urban PHC's.
3. Comprehensive medical care programme financed by government - 5% of GNP- with half disbursed to PRI's.
4. Stop privatization of public institutions through user fees, private practice and contracting out PHC.
5. Comprehensive based human power plan with no further commodification of medical education and promotion of one year compulsory rural posting.
6. Standard treatment guidelines use of diagnostics standard fees structure and regular prescription audit.
7. Rational Drug Policy including banning of irrational and hazardous drugs, introducing essential drugs, promoting generic use, quota's and price ceiling for rational drugs, regulating advertisements, formulating guidelines vaccines, control MNC's , promoting public sector and repealing new patent act,
8. Medical research on priority issues with ethical guidelines.
9. Access to safe and affordable contraceptives and abolishing coercive methods for limiting family size.
10. Support to traditional healing systems including local and home based healing traditions.
11. Transparency and decentralization in decision making process at all levels with Right to information and health policies after wider scientific, public debate.
12. Ecological measures to check communicable diseases including health impact assessment, decentralized surveillance, and gender sensitive services.
13. Facilities for early detection and treatment of non communicable diseases.
14. Women centred health initiatives
15. Child centred health initiatives
16. Measures for occupational and environmental health
17. Measures towards mental health including community support and community based management





18. Measures to promote health of elderly
19. Measures to promote health of physically and mentally disadvantaged
20. Effective restrictions on promotion of tobacco, alcohol, and other addictions

(see charter for further details in the context of each demand.)

#### 10. JSA Aims :

Since 2000AD the Jana Swasthya Abhiyan at National level has evolved the following:

- i). Draw public attention to adverse impact of policies of iniquitous globalization
- ii). Campaign to establish Right to Health and Health care as basic human right
- iii). Campaign to re-establish Health and equitable development reestablished as priorities at local and national level with PHC as major strategy
- iv). Confront commercialization of health care and establish minimum standards and rational treatment guidelines
- v) Build integrated comprehensive and participatory approaches to place people health in people's hands.
- vi) Network with all those interested in promoting people's health to bring together a wide variety of people's initiatives to organize and access better health care while also contributing to sustainable long term solutions to health problem.

#### 11. The JSA organization structure :

This has evolved as follows,

- A national coordination committee with a chairperson, a convenor and a set of joint national convenors (presently nine)
- A JSA national secretariat with a secretary and support team (presently in Bhopal – Dr. Ajay Khare)
- The NCC consists of 17 networks and 5 national resource groups presently.
- There are state units /contacts in 21 states- Andhra, Gujarat, Kerala, Rajasthan, Assam, Haryana, Madhya Pradesh, Tamilnadu, Bihar, Himachal Pradesh, Maharashtra, Tripura, Chattisgarh, Jharkhand, Orissa, Uttar Pradesh, Delhi, Karnataka, Punjab, Uttaranchal, West Bengal. Each state has its own arrangement for the secretariat and the coordination function.

#### 12. Strategies and Techniques adopted by JSA

- Public information and education on health issues largely through publications, meetings and other events, press conferences and media information
- Social mobilization and protest actions by means of health enquires, public hearings, health diagnosis, seminars and cultural events.
- Representation to decision makers on policy concerns, grievances and gaps in health services, while seeking increased representation for communities in local health related decision making.
- Health surveys and studies to understand and highlight health issues concerning the people
- Organisations of people through community health programmes, to help the poor cope with the burden of disease, gain better access to public health services and monitor health services

#### 13. JSA activities undertaken so far :

(The states could reflect on how they have been involved in these. This is just a check list of the key initiatives and opportunities)

- i) Critique of National Health Policy 2002
- ii) Critique on National Policy on Pharmaceutical
- iii) Campaign against the practice of sex selective abortions
- iv) Association with Right to Food Campaign





- v) Asian Social Forum, Hyderabad, 2003
- vi) Hunger Watch Group
- vii) International Health Forum, Mumbai, 2004 & World Social Forum 2004
- viii) Public dialogue on Health with Political parties 2004
- ix) Right to Health Campaign- Regional and National Public Hearings
- x) People's Tribunal on Population policies.
- xi) Campaign towards amending Patent Act
- xii) Drug policies seminars at different levels
- xiii) People's Rural Health Watch
- xiv) Tenth International Women and Health meeting including state and zonal meetings
- xv) Engagement with Global People's Health Movement
- xvi) Engagement with Global Health Watch
- xvii) Engagement with International People's Health University
- xviii) Engagement with WHO Commission for Social Determinants of Health
- xix) National Health Assembly , Bhopal 2007
- xx) Other state level campaigns and initiatives.

#### 14. Publications of JSA/ PHM

The JSA has been involved with the following publications at the National level and Global level some of which have been translated by the states into local languages. The following is an incomplete check list.

- i) What Globalisation means for People's Health, 2000 ( booklet)
- ii) Whatever happened to Health For All by 2000AD, 2000 ( booklet)
- iii) Making Life Worth Living, 2000 ( booklet)
- iv) A World Where We Matter, 2000 ( booklet)
- v) Confronting Commercialization in Health Care, 2000 ( booklet)
- vi) Indian People's Health Charter, 2000
- vii) People's Charter for Health , Global, 2000
- viii) Health for All Now, The Peoples Health Source Book, 2004
- ix) Jan Swasthya Abhiyan'– People's Health Movement in India – Pamphlets
- x) The Mumbai Declaration, 2004
- xi) The Cuenca Declaration , 2005
- xii) Global Health Watch – I , 2005
- xiii) Globalization and Health , 2006 ( NHA 2 booklet)
- xiv) Health Systems in India , Crises and Alternatives, 2006 ( NHA2 booklet)
- xv) Women's Health , 2006 ( NHA2 booklet)
- xvi) Campaign issues in Child Health , 2006 ( NHA booklet)
- xvii) New Technologies in Public Health – Who pays and who benefits? , 2006 ( NHA 2 booklet)
- xviii) The impact of the Global Trade Regime on Access to Medicines : A case study of HIV-AIDS treatment access , 2006 ( NHA2 booklet)
- xix) People's Rural Health Watch, 2008
- xx) Global Health Watch –II, 2008

**This basic outline and checklist of various aspects of the JSA should be kept in context as each state makes a participatory appraisal of its own evolving network and documents its involvement in events and opportunities at both national and local levels.**





## Section- III

### Methodology and Time frame of Assessment

Keeping the last two sections in context the process for Participatory Assessment for Movement Strengthening at state level and at national level, would consist of the four following phases of activity including evidence gathering, dialogue and discussion.

#### Phase-I

Theme: **Situation Analysis** (15<sup>th</sup> July ' to 14<sup>th</sup> August 2000)

#### Phase-II

Theme: **Assessment of Movement Experience** (15<sup>th</sup> August to 14<sup>th</sup> September 2010)

#### Phase-III

Theme: **Participatory Assessment of Situation and Experience Assessment.** (15<sup>th</sup> Sept to 14<sup>th</sup> Oct 2010)

#### Phase-IV

Theme: **Evolving Plan for Movement Strengthening** (15<sup>th</sup> Oct to 14 Nov 2010)

This is a suggested schedule and may be modified /adapted to each state situation if necessary.

### Method.

#### Phase One

1. It is suggested that one or two, young JSA related volunteers from one or more of the organizations/networks related to the state JSA, are selected as volunteers to collect the following information from files, documents, minutes, publications, newspaper cuttings and other materials, about JSA activities since 2000 AD. Some key informants, who have been in key leadership/coordinators positions in the state may be interviewed to get an orientation about all the activities and leads to access the required documents and reference material.
2. The evidence will include the state contribution to all or as many possible of the items listed in section-II. The list has been drawn keeping the Indian People's Health Charter and the JSA pamphlets in mind and the states may use this as reference check list to evolve their own situation analysis and activity report. ( see section two )

#### Phase - Two

3. This report/document prepared from phase one will be circulated to all concerned in the state. Each state JSA may already have its own emailing list, otherwise a list of contacts can be prepared as part of this phase and the initial document compiled in phase --I circulated to all concern for additions/modifications/ further details.
4. At a JSA State meeting -- this report can be reviewed and a list of key stakeholders which include network or ngo representatives in the state and key individuals and resource persons may be administered a SWOT questionnaire where they are requested to list out the Strength's, the Weaknesses, the evolving Opportunities and some of the problems/ challenges. (Threats) of the experience of JSA in the last decade.
5. If possible interactive discussion should be held with at least a few key people if not all. If the sample includes network representatives who are involved; network representatives who were involved earlier and are less involved now; and network representatives who should be involved but are not doing so - then we will be able to get a comprehensive picture of the challenges in network strengthening by





identifying the factors that promote involvement and factors that reduce/distort or decrease involvement. For the interactive discussion (one on one) it may be useful to enlist a volunteer who has interview skills but has not been deeply involved with the day to day activities of JSA, to enhance the objectivity of the interviews.

### **Phase- Three**

6. A report should be evolved with a sensitive analysis of the documents / reports that arise out of phase one & two activity. This report needs to keep in mind the following methodological cautions:
  - i) Identify issues removing focus from individuals and organizations
  - ii) Focus on what to do in the near future not only on what failed in the past
  - iii) Interpret findings keeping in mind the diversity/heterogeneity of the group.
  - iv) Focus on facts /evidence not on opinions/feelings only.
  - v) The analysis should lead to a plan of action not only stop at diagnosis of the challenge.
  - vi) A SWOT approach identifies, strengths, weaknesses, opportunities and threats may be used which will help to balance the weaknesses /problems with the strength's and opportunities.
7. During this phase as was discussed at the NCC meeting, a days discussion may be organized and one or two senior JSA activists from other states, if available may be invited in solidarity, to enhance a certain objectivity in the ensuring discussions. The focus should be on problem solving not just problem analysis.

### **Phase – Four**

8. A short 2-3 page document could be prepared in English and the vernacular with a suggested plan of action focused on a period of Six months – Nov 2010 to May 2011 so that a sense of urgency and practical action is facilitated. This may be discussed and outlined at a state meeting. It will also help to focus activity as a build up to a national health assembly and or next Global Health Assembly scheduled in South Africa, some time between July to September 2011.
9. A short summary of the process with useful details about JSA – state activities /structure/organizational features/publications and other outputs etc may be prepared with suitable photographs and visuals and uploaded on the jsa website.
10. Ideally all these state processes could be reported at a National level JSA meeting anytime after December 2010, where intra --state learning may be facilitated and the JSA network strengthening takes place at all levels- building on positive experience and best practices .

At the national level meeting a national level process which would be similarly phased out could be planned by the secretariat in Bhopal and evolve as a parallel process to the state reviews.

### **Resource Support:**

1. Each state will plan and facilitated this learning process within its own existing decision making and funding structures.
2. The Centre for Public Health and Equity (SOCHARA) Bangalore and especially Dr. Ravi Narayan, its Community Health Advisor will be available for consultation/ support, accompanying the state level PANS volunteers through the process – supporting both content and methodology through peer consultation and review.





3. Each state is requested to identify these volunteers and put them in touch with CPHE. Each state should also identify one senior JSA activist who will coordinate the process
4. An e-group can be setup with the id's of all the state PANS coordinators and volunteers and from time to time notes, reflections, plans, checklists, and other news can be circulated especially, once in a fortnight to keep up the momentum of the common learning process.

#### **In summary**

The Participatory Appraisal for Network Strengthening (PANS) is being planned as a collective learning exercise so that all of us interested in the further growth, evolution and mature development of the JSA process can learn from each other, at state, network, and individual level through a interactive participatory exercise which ultimately will strengthen the collectivity of JSA, the information on the JSA website and provide a new boost of energy as we move beyond the tenth year of our existence towards the third global People's Health Assembly (2011)

**12<sup>th</sup> July 2010**

**Facilitating Team**





As was decided at the national level, a Jan Aarogya Abhiyan (JAA) self review process has taken place in Maharashtra. Based on the discussion at the national level and the guidelines that have been received from the national level, overall planning of this process was done during the state level JAA meeting on 6<sup>th</sup> April, 2010. It was agreed that as per the note received from National level, the following points need to be addressed during the JAA self-review –

1. Capacity of JAA to engage with major issues outlined in the People's Health Charter.
2. Was the working style of JAA inclusive, encouraging people from different backgrounds, to participate in the decision making and its implementation?
3. What have been members' expectations from JAA and what has been their contribution to JAA?
4. Regularity of functioning – Was JAA working regularly or only occasionally, say once or twice a year?
5. What has been the response of JAA constituents to State level issues, initiatives ?
6. What has been the relationship of JAA with National JSA? How has JAA been responding to programmes/appeals from the national secretariat? Has JAA been pro-actively approaching the National JSA with any suggestions, programmes?
7. What has been the quality and intensity of efforts in JAA ?

Based on the above mentioned points as well as some others, a questionnaire guideline (annexure 1) was drawn to guide the self review at both local and state level self-review. Since many activists can not spend time and money to travel to a state level meeting, it was decided that local JAA units would use this questionnaire guideline to conduct a self review in their respective areas. This questionnaire-guideline would be just a guideline, a kind of a check-list so that the important points are not missed during the self-review. JAA activists can modify it as per local need. Such local meetings would allow all JAA activists to participate in the self-review process. Those who can not participate in this meeting can send their response in writing. There will not be any quantitative analysis of these responses; but they will be taken into account during the state level self-review. It was also decided that the same questionnaire-guideline would be used at the state level self-review meeting and we would request two JSA activists from outside Maharashtra to participate as facilitators in this state level JAA self review meeting. All this was communicated to Ravi Narayan to seek his suggestions.

JAA units in Pune and Mumbai convened a special meeting on 31<sup>st</sup> July and 19<sup>th</sup> August 2010 respectively to conduct a self review based on this questionnaire guideline. Following this, Renu Khanna (JSA Gujarat) and Rakhal Gaitonde (JSA Tamil Nadu) stretched their ever busy schedule to come to Pune on 20<sup>th</sup> August for the state level self-review meeting. It was decided that during this meeting we would go a little more systematically to discuss the following five major issues that emerge from the 7 major points mentioned above. We kept half to one hour for each of these five questions and two hours were allotted for issues which may not be covered by these five questions (one hour was allotted for a discussion on relationship between JAA and Community based Monitoring -CBM)

1. JSA's people's Health Charter has 20 major demands/action points. Out of which how many have been taken up by JAA? Which ones?
2. Do you consider the working style of JAA to be inclusive, encouraging people from different backgrounds, to participate in the decision making and its implementation?

## The main focus areas co-

- Overall experience of organ...
- Challenges etc.
- Skills and strengths gained.
- Strategies that worked, did not
- New friends / associates four
- Gains for JAAK and chang
- and other public hearing
- Follow up done in districts

## District – wise pre

### 1. District: CHITRADURGA

#### 1. Public hearing Public dialogue, p

- Energy and the positive attit
- NGOs together
- There is a doc who has bee
- The PHCs and the health c
- There is an awareness, a
- The DHO now personally
- how things are being run

#### 2. What skills and strengths you gai

- Worked on the areas of wo
- The people and the off
- The public now know that
- us have been able to know
- learning that we got from J
- interaction with state conv

#### 3 What are the strategies emp

- Case studies: w
- the denial cases,
- There were a lot of
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- Networking / C
- groups, and ot
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3. Do you consider JAA to be regular in functioning (meetings/ communication and correspondence)?
4. Has JAA been adequately responding to programmes/appeals from the national secretariat?
5. Has JAA been pro-actively approaching the National JSA with any suggestions, programmes?

This above broad plan of the meeting was broadly agreed upon at the beginning of this meeting on 20<sup>th</sup> August. However, it was felt that we should start from a brief reporting of the self review meetings in Pune and Mumbai. Accordingly, Kajal Jain and Anant Phadke tried to briefly report the discussions during these two meetings. (Unfortunately Mumbai JAA representatives had to drop out at the last moment and hence Anant made a brief presentation in Hindi based on the report received from Mumbai JAA by email).

**1. JSA's people's Health Charter has 20 major demands/action points. Out of which how many have been taken up by JAA? Which ones?**

It was agreed that the twenty point People's Health Charter is quite a comprehensive policy level action plan and it is not possible for any state JSA unit to take up all the issues included in the Charter. The very nature of some of these issues is such that only a national level coordinated action make sense. For example, pharmaceutical policy, medical education policy etc. Within these limitations, JAA started off well in 2000 by planning actions on a range of issues. Though the main focus of JAA has been provision of primary health care services in the rural areas, other issues were also part of the actions.

People working on a variety of issues (mental health issues, herbal medicines, role of health professionals in helping victims of domestic violence, health care for urban poor, deficiencies in ESIS), have been active in JAA and JAA's work on these issues had started along with the work related to provision of primary health care services in the rural areas. However, from late 2003, with the launching of right to health care campaign, JAA's work got more and more focused on deficiencies in the primary health care services in rural areas. These other issues were included as part of this overall agenda but some of them lagged behind because the general PHC services have been so deficient that it was much more difficult to press for availability of specific services for different sections of vulnerable people. Specific cells formed within JAA on these issues to give justice to these issues did not take off very much. Sum total effect has been that many of the issues included in the Charter have been taken up by JAA mainly when there was some all India action plan decided at national level (for example on issue of patents, midday school meal, election manifesto etc). The activities of the women and health cell had a different trajectory. It was more and more integrated into the follow up of the IWHM (International Women's Health Meet), which subsequently in 2006, developed into Maharashtra Mahila Arogya Hakka Parishad.

It was felt that we need to simplify and popularize the Charter and this could be an important activity in the near future.

**2. Do you consider the working style of JAA to be inclusive, encouraging people from different backgrounds, to participate in the decision making and its implementation?**

It was generally felt that the working style of JAA has been inclusive, encouraging people from different backgrounds to participate in the decision making and its implementation. However, some people who are primarily or almost exclusively focused on a particular issue (like mental health, HIV, urban health care) did not feel much encouraged to participate when the focus of JAA activities became advocacy for improving deficiencies in general PHC services. It may be noted that despite probing,

#### 4. The Road ahead for JAAK

Some concrete suggestions came up from the discussion. Some further and what the road map should look like.

##### *Strategic issues*

- Begin the movement at the grass root level with community workers
- Involve younger activists in JAAK
- Connecting with other networks
- Bring the likeminded people and organizations into the movement
- Involve PRI in all the discussions
- Train the various committees that will take up the rights – this will help identify, fix

##### *JAAK form, structure and capacity-building*

- Consolidate it at the state and at the district level. Have representatives at the Zilla Level and have representation at the state health department.
- Have an organization that can take up the issues. It can be the focal point where all the issues related to the movement further.
- Training in using technology to do documentation/research and advocacy.
- Immediate helpline for the health issues.
- Encourage, train health activists to take up issues.
- At the Zilla level, have a JAAK committee.
- Exposure visit/or learning for the health activists.

##### *Content*

- A holistic and comprehensive movement covering housing, water, education, health, etc.
- Preventing privatizations of health services.

Akhila and Premdas

Annexure:

The District-wise comparison of the district processes of strengthening JAAK



no experiences have been reported of anyone who is interested in getting involved in JAA, being discouraged or sidelined. Hence by and large JAA has provided an inclusive space for health activists, but level of action on issues has depended on actual initiative being taken up by concerned activists.

The different cells in JAA need to be reactivated.

**3. Do you consider JAA to be regular in functioning (meetings/ communication and correspondence)?**

Initially for the first five years JAA used to have a state level meeting every six months. Later on such planned six monthly meetings became infrequent. To save on time and expenses for travel, general JAA meetings have more and more linked to some state level programmes like state level delegation to higher officials or health minister, state conventions on patients rights and now state level meetings related to CBM work.

It was decided that henceforth, we should have at least one state level meeting in a year for full day to discuss the overall work of JAA. Secondly as was done in the initial period, leading elements in JAA need to visit various local units to strengthen them and we should also think of having state JAA meetings in different regions of Maharashtra.

As regards communications, there has been quite frequent email communications and phone calls from the co-convenor's office in Pune to JAA constituents and the email list continues to be quite broad even though many of the recipients are currently not active in JAA.

Four regional co-convenors from outside Pune were nominated during the state level JAA meeting with the expectations that they would keep active dialogue with JAA constituents in their region. However, this has not happened much.

**4. Has JAA been adequately responding to programmes/appeals from the national secretariat?**

Participants felt that JAA has almost always responded positively to the various programmes that have been decided at national level, for example,

- Right to Health Care Campaign: NHRC Public Hearings and national reviews 2004-07
- Action programme about revised Patent Act 2005
- Follow up with NHRC in 2005-06 about implementation of NHRC's action plan about health as a human right.
- Various meetings related to NHA II Bhopal: State Health Assembly
- Discussion related to National Health Bill on 30<sup>th</sup> October, 2009
- Pre-election health manifestos

**5. Has JAA been pro-actively approaching the National JSA with any suggestions, programmes?**

From Maharashtra, JAA has suggested a number of programmes to national JSA. For example -

- The national public consultation on denial of health care to establish dialogue with Justice Anand, NHRC (programme in Mumbai, September 2003) followed by Public hearings with NHRC
- The issue of intra dermal rabies vaccination
- Proposal for second round of public hearings with NHRC
- JSA position and intervention on Urban Health Mission
- Patients rights in private medical sector.

Unfortunately for various reasons the last three programmes could not take off at the national level.

**Use of RTI and filing complaints with the lokayukta:** Some districts had understood how to use the RTI and use the vacancy position, drug supply at a PHC. They had started filing complaints with the lokayukta. They had also filed discrimination.

**Post card and letter campaign - Flooding the district administration:** Some districts such as Bagalkote & Haveri had started sending post cards complaining of various kinds of issues. This strategy had also managed to grab attention of the district administration willing to listen to the activists' demands and demands. In one instance letters about denial of health care were sent to the health commissioner. The former asked for strict action would be taken against the erring officials.

**Staging protests and dharna:** One district had started staging protests at the district administration office demanding be invited to meet the DC and their complaints be taken.

### 3. Reflection on strengths and challenges

The sharing led to the next step in the reflection. The strengths are so far, how it needs to be continued and what needs to be addressed.

**Strengths:** As discussed earlier, the districts had received a lot of support from various local stakeholders. The JAAK was becoming well-known as a platform where people in communities through awareness that health rights issue was no longer a secret. They had managed to take ownership of the issue. They had managed to get the support of communities. They felt they had a thorough understanding of the issue that they were playing the role of a watchdog. In fact their efforts had been compelled to respond and address complaints.

#### Challenges:

- All organizations in JAAK do not have the same level of understanding.
- While community has been involved, the role of the district administration is not clear.
- Health activists need more inputs and training. For instance one area which the activists need to understand is judicial activism as it related to health rights.
- Activities are happening in fits and starts, not as a collective effort.
- Given that JAAK is presently very small, the initiative to communicate and



## **Relation between Community Based Monitoring and JAA**

It was decided that this issue needs specific discussion because CBM has been a very important programme for many of the JAA constituents, especially those working in rural areas.

It was pointed out that in the PHCs where CBM process has taken place, the PHC staff is under some public pressure and health services and behaviour of the staff has improved. During the health rights campaign in 2004 – 2006, we had organized six Jan sunwais in Maharashtra. In the CBM process more than 100 Jan sunwais have taken place during the last two years. The analysis of report cards shows that in most PHCs included under CBM, health care services have improved. Thus the objective of JAA in taking up the health rights campaign has certainly been achieved to a certain extent because of CBM process. However it was felt that at the same time JAA's organizational work has suffered. Secondly, programmatically also as mentioned above JAA's focus has narrowed down in practice. This is because CBM was a very intensive process, and activists involved as CBM partners, who were also part of JAA had to concentrate on CBM work and these activists had much less time and energy for JAA work as such.

It is pretty clear that JSA national and JAA have been instrumental in fostering the CBM process. This point has not been emphasized in our orientation sessions of CBM. Now in the coming period some strategy needs to be worked out about how CBM process can strengthen JAA. For example, in various meeting and programmes of CBM a simplified version of People's Health Charter can be specifically talked about and the CBM process should be seen as part of the broader agenda of the Peoples health movement.

### **Future strategy:**

It was felt that JAA has not grown in recent years and needs to be strengthened. We need innovative strategies and programmes to do this. For example, we should simplify and popularize the People's health charter and also talk more about JAA in our various programmes.

It was also felt that to save time and money for travel, it is alright to link some of the state level JAA meetings with state level CBM meetings because many of the JAA members are involved in the CBM process and travel related time and money can be saved. But at least one state level meeting in a year should be convened only for JAA work and due attention should be given to other points from the people's health charter on which various JAA constituents want to work. We had some state level meetings on patients right in private hospitals, national urban health mission. More such meetings and issues need to be taken up.

There should be regional meetings of JAA in various parts of Maharashtra and/or we should also think whether senior JAA activists can visit various areas to foster programmes in various regions and strengthen JAA organizationally. The co-convenors should be reappointed in each region, they should become active and various cells in JAA should be revived. New groups should be contacted to be involved in JAA.

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- Overall experience of organizing public dialogues in districts – positive experience
- Skills and strengths gained by the activists
- Strategies that worked, did not work, and why
- New friends / associates found. Good govt. support found in the process
- Gains for JAAK and changes that have happened (CEO and other public hearing.)
- Follow up done in districts and tasks at hand

### Reflection of the journey thus far with the health system

Most of these active JAAK members had got into the health system in the last 10 years (2006 onwards). Most of them expressed their appreciation for the process organized by JAAK on 31<sup>st</sup> March 2009, in which 100 people from 12 districts participated, generated a list of demands, and health activists then decided to take the public hearing process forward, holding such similar processes. During the process, they shared their experiences, gave feedback on JAAK's work, and discussed the way forward.

**Sharing of experiences thus far :** The activists shared their experiences of working with various marginalized groups and with several years of experience on issues related to health and other basic amenities. Exposure to health system issues and there was a lot of new learning about the system and the strategies they used in their work with the health system.

## 2. On Processes and Strategies:

**Public hearing:** One such strategy which found to have had a positive impact at many levels: They found that they had been able to learn about the gaps in the system, mobilize attention for activists' demands from the community, and had been successful in seeking a response from the government. Appointment, distribution of *madilu* kit (maternal and child health wall along with PHC timings, staff, drug status, etc.), and activists were able to find new alliances, generate public support, attract media attention and support for the demands from the panchayats and JAAK's manifesto and the demands from the panchayats in the *gram sabha*. After the public hearing, JAAK activists when they faced harassment from the government, some challenges as well. In one district after the public hearing, all invited government officials were not present on the pretext of some work or the other. Similarly, in another district, there were many who had joined in the hope of getting some funds, but there were no funds they had dropped out.



**Questionnaire Guideline for Self Review of Jan Aarogya Abhiyan  
(Maharashtra)**

1. Name of the respondent (Optional)
2. Name of the organization:
3. Location and address:
4. Years of association with JSA
5. Status of association: Officer bearer/ Core Group Member/ Member/ Acquaintance
6. Amongst the **State level/ state wide activities taken up by JAA** since 2001, which are the activities in which you have participated? What has been your impression about the involvement of people, of activists in these programmes? (pl see the table at the end of this questionnaire)
7. Which were the local JAA activities in which you have participated?
8. Were you an associate of JSA in the past and not currently engaged with it? If yes, then please mention the reason for the same.
9. JSA's people's Health Charter has 20 major demands/action points. Out of which how many have been taken up by JAA? Which ?
10. What have been your expectations from JSA?
11. Do you think your expectations have been met?  
Pl illustrate by giving concrete examples.
12. Do you consider the working style of JAA to be inclusive, encouraging people from different backgrounds, to participate in the decision making and its implementation?  
Please illustrate by citing concrete examples.
13. Do you consider JAA to be regular in functioning (meetings/ communication and correspondence)? Please substantiate your response.
14. Has JAA been adequately responding to programmes/appeals from the national secretariat? (National Health Assembly, Programmes with NHRC, )
15. Has JAA been pro-actively approaching the National JSA with any suggestions, programmes? Please substantiate your response?
16. Please list three activities/ programs/ issues taken up by JAA and give your comments on the quality and intensity of those?
17. Any other thing you would like to share about your interaction with JSA.
18. What are your suggestions to
  - a. further develop the work of JAA
  - b. further strengthen the JAA organizationally

What responsibility would you like to take about these two aspects?





Participation in State level JAA Programme			
S.No.	Nature of State level JAA Programme	Nature of your participation	Level/type of involvement of people, of activists in these programmes
1.	PHA campaign in 2000 / preparation and publication of Marathi version of People's health charter		
2.	Preparation for and participation in NHA-I in Kolkatta		
3.	Follow up with Dr. Salunke after the State Health Assembly in November 2000		
4.	Critique of the National health Policy 2001		
5.	Critique of Urban Health Policy		
6.	Dharana in Azad maidan for increasing the health budget		
7.	Campaign and lobbying for BNHRA Rules		
8.	Campaign and lobbying for patients rights		
9.	Health rights convention Sept. 2003		
10.	Health rights campaign / denial cases / jansunwai 2004-05		
11.	Follow-up of bilateral enquiry of denial cases, 2004		
12.	Follow-up with Dr. Doke for improving of health services, 2005		
13.	Participation in Mumbai Convention against two child norm, Dec. 2005		
14.	Preparation for state level convention Feb. 2007		
15.	Preparation of publications in Marathi for NHA-II.'2007		
16.	Preparation and participation in NHA-II in Bhopal 2007		
17.	Publicizing JAA demands on World Health Day, 2008 to 2010		
18.	Publicizing JAA Manifesto for 2004 and 2009 elections		
19.	Signature campaign for patients' rights		





- Despite its limitations it was decided to make use of whatever space created by this amendment and also to push for Patients' Rights under the amended BNHRA

### **FORMATION OF RULES UNDER BNHRA**

- Assignment to CEHAT by Health Dept. for preparing rules under BNHRA through multi stake holder participation in which JAA representatives played important role
- Special JAA meeting in Pune to give suggestions about these rules, especially about Patient's Rights

### **ADVOCACY FOR FINAL APPROVAL OF THESE RULES**

- Draft rules under BNHRA prepared by the Working Group were submitted by CEHAT to the Health Dept. They were slightly modified by the Health Dept. and put up on their web site in July 06
- But no final approval by the Health Minister till today!
- Articles in newspapers, press releases, media interviews
- Dialogue with doctors' organizations- meeting in Amaravati and in Shahade,
- Repeated follow up with Director of Health Services, Maharashtra

## **V. Advocacy For Patients' Rights In Private Hospitals**

- Public meetings (Dahanu, Pune, Kolahpur, Ambejogai) during June to August 06 demanding inclusion of Patients' Rights in the minimum standards in BNHR rules and signatures collected from people
- These meetings were either co-organised with IMA in respective towns or IMA representatives spoke in these meetings and declared support for the Patient's Rights as formulated in BNHRA rules
- Letters by different NGOs to the Health Minister urging him to inclusion of Patients' Rights in the minimum standards in BNHR rules
- Signature Campaign from April 08 in amongst lay-People demanding immediate sanction to these draft rules on the Web-site
- JAA delegation met all the three Health Minister Dr. Mrs, Mundada, Dr. Shingane, Mr. Suresh Shety and follow-up
- Collecting signatures of editors of leading dailies in Pune and other intellectuals (in total about 100) demanding immediate sanction to these draft rules (April 08)
- Patients' Rights Convention in Pune (July 2008), Chief guests Dr. Narendra Dabholkar, Dr. Amar Jesani

In this convention, IMA representatives declared their support to Patients' Rights

- Series of meetings with IMA representatives and FOGSI President leading to Joint Brochure and Joint Press Conference (Feb. 2009) by:
  - Rugna Hakka Samiti-Pune,



- Jan Aarogya Abhiyan,
  - Indian Medical Association (IMA) and
  - Federation of Obstetricians and Gynecologists (FOGSI)
- on Patients' Rights and Responsibilities

- Special sessions with IMA doctors in Sangali, Satara, Shahade on Patients' Rights and Responsibilities
- State level Convention in Mumbai (7<sup>th</sup> November 08); Prof. Jogendra Kawade, a prominent political leader was the Chief Guest. Press conference after this convention was well covered by print and electronic media. Demands projected –
  - The draft rules (including rules for observance of Patients' Rights) under BNHRA (amended) 2005 be immediately approved and implemented.
  - Civil Society organizations should be involved in the monitoring of implementation of these rules like what is happening in the Community Based Monitoring (CBM) in the National Rural Health Mission (NRHM).
- Liaison with selected MLAs so that the issue of pending approval is raised in the Vidhan Sabha in the winter session 2008
- Signature Campaign again in December 08 - January 2009 as a background to this lobbying; well covered in local press
 

Demonstration in Gadhinglaj (Kolhapur district) in front of the Prant office, 8<sup>th</sup> December
- Using a specially prepared pictorial exhibition prepared by SATHI on Patients Rights, different organizations collected signatures of lay people demanding immediate sanction to these draft rules
- Patients rights poster exhibition at Shahada - 3slums, 10 villages in Shahada block, Nandurbar district, Dec. 10
- Reservation of beds for poor people in Trust Hospitals, Patients' Human Rights
  - Mumbai High Court's directive as a fallout of a PIL-
  - For patients from poor and economically weaker sections, 10% beds should be reserved for each of these sections for free or subsidised treatment
  - State level consultation by JSA with participation of Member, NRHC in Mumbai in January 2010, with senior health officials in Maharashtra about Patients' Human Rights in trust hospitals/private hospitals.
  - JAA has published a booklet giving details of this scheme and JAA constituent organizations are using this booklet

## VI. Activities of Mumbai JSA

- Workshop on Community Based Monitoring in the Urban Context: 26th Nov, 2010
  - Health, ICDS, PDS, Water and Sanitation.
  - Drafting of working papers on community monitoring in Health, ICDS, PDS, Water and Sanitation at Mumbai level.
  - Initiation of a multisectoral CBM Model at Malawni in Malad, (western suburb in Mumbai).



- Consultation on Health Concerns of Vulnerable Groups: 14th 15th Dec, 2008
  - Such as Street children, children of sex workers, sexual minority, women in sex work, HIV positive women, disabled, people working in hazardous work conditions, children at work, etc
- Consultation on Urban Health and NUHM : Brainstorming with various stakeholders, July 2008
- 2008, April 7th- Public Meeting on Patient rights
- 2010, April 7th- Training of trainers on Patient Rights, with community workers
- 2011: 7th April- Press conference cum public meeting, a survey of more than 15 slums areas covering about 300 PHC findings presented to the Health Minister and the Chief Minister
- JSA Mumbai Delegation to the Health Minister: 21st June 2011, About availability of Schedule H drugs, Patients rights, user fee hike in public hospitals.

## VII. Organizational Development

### JAA state level convention, Pune, 5-6 March 2011

- Over 170 representatives from health sector and social organisations drawn from 30 districts across Maharashtra participated.
- Report has been circulated on PHA-NCC e-group
- Plan to launch campaign on key issues:
  - Sharp hike in fees at Medical college hospitals,
  - Massive shortage of medicines,
  - Violation of patient's rights in private hospitals

### Follow up meetings and programmes –

- 8th July 2011, Pune, 21st Sept, 2011

#### Letter to health minister - Pen Pathava Abhiyan- for BNHRA Patients Rights

Name of NGO	Date	No of Villages	Press release
Apeksha Amravati	9-5-2011	12, 1 block	
Janarth Shahada	7-4-2011	30, 1 block	2 press releases
Rachana, Pune	5-5-2011	18 villages	
Samata, Beed	7-4-2011	1 block	Morcha to collector office
letter to chief minister, protesting against fee hike in hospitals			
Maharashtra ASHA worker union	21-4-2011	6 Blocks	
IHMP Pachod	7 -4-2011	2 Blocks	
JAA Gondiya	9-4-2011	Gondiya city	3 press releases
JAA Sindhurg	7 -4-2011	1 block	
Janarth Shahada	5-5-2011	30, 1 block	

Memorandum to the District Collector to take a action on private hospitals for sex selective abortion in particular area. August 2011, Beed- Samata & Manavlok

JAA would be a co-convenor in the **Upcoming Event: 22-23 Nov. 2011 at TISS Mumbai**

**State convention on accountability of Health and social services**

Participation by MLAs, Panchayat representatives, Health sector trade unions, Social sector networks incl. Right to food campaign,

Medha Patkar, Aruna Roy, MD NRHM, CBM and JAA activists from 12 districts, expected 200-250 participants; co-organised by JAA, coalition of CBM organisations and TISS.

**Objectives:**

To promote strengthening and modified generalization of Community monitoring of health services with broader socio-political support;

Discussion on models for community accountability of social services like food security, water, education;

Discussing alternatives to Lokpal for grievance redressal and ensuring citizens right to services.

**PANS process-**

- Planned during state level JAA meeting on 6th April, 2010
- Questionnaire for self-review circulated
- JAA units in Pune and Mumbai convened a special meeting on 31st July and 19th August 2010 respectively to conduct a self review based on this questionnaire guideline
- State JAA meeting for self-review organised in Pune on 20th August, facilitated by
  - Renu Khanna (JSA Gujarat) and Rakhal Gaitonde (JSA Tamil Nadu)
- Report circulated, separately attached note

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Maharashtra

# JAN AAROGYA ABHIYAN (MAHARASHTRA)

## MAIN ACTIVITIES SINCE 2008

### I.

### Advocacy for Improvement in Public Health Services

- **Fostering Community Based Monitoring of Health Services, attempt to make it 'CBM plus', to develop it as a broader activity for promoting health rights beyond project:**
  - Focus on grass root activities in monitoring and mobilisation
  - Jan Sunwais (170+ Jan Sunwais at PHC, Block and District levels in 3 years)
  - Regional workshops organised on CBM and health rights in 5 regions of Maharashtra, sensitised nearly 150 activists from additional organisations from various networks
  - State level dialogue events (Nov. 2008, April 2010) raising State level and broader systemic issues
  - Signature campaign in CBM areas on systemic and policy issues
- **Other programmes for improving Public Health Services**
  - Demonstration in front of the sub-district hospital, Gadhinglaj (Kolhapur district)
  - Follow up meeting in presence of Civil Surgeon-  
Corrupt doctors directly exposed,  
Promise by civil surgeon to take action
  - Patients' Rights Charter prepared by the Jan Aarogya Samiti put up in this Hospital
  - Threat to launch agitation due to non-functional sonography machine – machine repaired
- **Swine Flu epidemic 2008 :**

JAA criticises (July 08) unscientific steps and Patrak for lay people by Pune Municipal Corporation and demands

  - Evidence based measures for Swine Flu control
  - Appropriate guidelines, instructions to citizens and health care professionals
  - JAA prepares and distributes appropriate health educational Patrak for lay-people
- **'Peoples Health Manifesto- 2009' and it's Marathi version released on World Health Day, 7th April 09:**
  - Formulation of Maharashtra specific health manifesto keeping in view State assembly elections in Oct. 2009
  - Appeal to the political parties that they should incorporate it as a part of their election manifestos
  - Adv. Anand Grover, UN special rapporteur on right to health released this manifesto on 7th April 09
- **Pune Municipal Corporation budget, (April 2010) JAA protests**
  - Miserly allocation for Health-Care of poor people and
  - Excessive expenditure on health care of elected representatives
- **JAA criticises (February, 2011) 250% increase in rates in medical college government hospitals,**



- **Gross Shortage of Essential Medicines in PHFs - JAA criticises (July 2011) procurement Policy**

- Survey by JAA activists in Nov. 2010- Ten PHCs and 5 RHs in 5 districts, (69 and 92 medicines respectively) More than half medicines showed zero stock!

- JAA demands (July 2011) adoption of TNMSC model, criticises the new medicine procurement policy by the new Health Minister, Mr. Shetty in Press conference in Mumbai, -
- LAQ in Vidhan Sabha about this JAA report
- During the Monsoon session of Vidhan Sabha (August 2011)
- Lobbying during Vidhan Sabha in Mumbai with MLAs: Patients' Rights and Medicine Procurement system

- JAA opposes (Nov. 2011) Maharashtra Government's decision of privatization of all radiological services as shocking, retrogressive, and unnecessary

## II.

### Advocacy Against Privatization of Public Hospitals in Pune

- Follow up PIL against privatization of Jorvekar clinic, successfully stalled privatization
- Agitation against privatization of Dalavi Hospital by the Pune Municipal workers' union and JAA Pune.
  - One day strike by Pune Municipal workers
- PIL in Mumbai high court against this privatization

## III.

### Advocacy for Intra-Dermal Regime of Anti-Rabies Vaccine

- National JSA's intervention led to the approval in October 06 by DCGI of Intra-dermal regime of rabies vaccine.
- Follow up of this decision with the Maharashtra DHS
- JAA links regular shortage (July 08) of ARV in Sassoon Hospital Pune to the non-implementation of the directives of the DCI to give ARV intra-dermally
- Finally DHS came out with a circular in October 08 giving instructions to use of Intra-dermal regime of rabies vaccine in Public Health Facilities

## IV.

### Advocacy for rules for Private Hospitals including Patients Rights for Private Hospitals

#### BACKGROUND

- 'BNHRA-1949' only on paper for 55 years. No rules framed. Advocacy for many years by civil society groups to amend this act and to frame rules under it
- Due to this pressure and also of the World Bank, act amended in December 2005
- The amended act is quite inadequate. It merely mandates observance of floor space-patient ratio and nurse-patient ratio



# JANA AROGYA ANDOLANA KARNATAKA (JAAK) PARTICIPATORY ASSESSMENT FOR NETWORK STRENGTHENING (PANS) COMPILED REPORT

Learning review of Janaarogya Andolana Karnataka, August 2010- July 2011

PANS COMMITTEE For JAAK : Dr. Prakash Rao, Dr. Akhila Vasan, E. Premdas & Asha Kilaru

Report compiled by : Akhila Vasan and E. Premdas

## INTRODUCTION:

Janaarogya Andolana, Karnataka (JAAK) or People's Health Movement in Karnataka is the state chapter of JSA in Karnataka and this coalition works under the broad framework of People's Charter for Health with 'Health For All, Now!' as the key theme. From 2000 – 2006 BGVS was the secretariat and from 2006 to date, Community Health Cell is the secretariat of JAAK in Karnataka.

**Background:** JAAK has brought together a number of state level networks / organisations around the issue of Health & Equity and Health Rights. Right from pre- first People's Health Assembly mobilisation upto now, JAAK has been actively involved in the national and state level campaigns; Karnataka was also part of the NHRC Public Hearing on the denials of Health Care in 2003. The documentation of cases of denial of health care by members of JAAK; three state health assemblies have been held in Karnataka (2000, 2005, 2007); Janaarogya Andolana, Karnataka has made several efforts in the past years to mobilise people around the health issues; Since 2006, a statewide campaign has been launched towards revitalisation of the Primary Health Care in Karnataka under the broad framework of Right to Healthcare. Some of the efforts that have been undertaken to address the Right to Health issues in Karnataka

- It has brought together a number of state level networks / organisations around the issue of Health Rights
- Karnataka was also very actively involved in the First People Health Assembly. Health Messages were taken to the people by street theatre and culminated in the first State Health Assembly at Davanagere in 2000
- In Karnataka a health task force was constituted in 2000 to look into the public health system. A number of eminent health activist experts who were part of People's Health Movement were part of this task force and their recommendations were enshrined in the Karnataka Health Policy document which was passed by the state cabinet.
- Karnataka was also part of the NHRC Public Hearing on the denials of Health Care in 2003. The documentation of cases of denial of health care by members of JAAK
- Public hearings were held where the cases were presented before Government officials and NHRC members. The NHRC gave some specific recommendations to the Central Government, State Government and civil society based on the public hearings and subsequent discussions
- In 2005, the second State health Assembly was held in Karnataka before the 2<sup>nd</sup> International People's Health Assembly at Cuenca in Ecuador, South America.



- Janasrogya Andolana, Karnataka has made several efforts in the past years to mobilise people around the health issues.

The chronological compilation of events is provided in annexure 4 for more details on the key events from 2000 - 2011.

### **Organisational Structure:**

1. **State Coordination Committee:** Consists of the following:
  - 20 State level networks/organizations which have been there from the starting of JAAK
  - 10 district JAAK forums (Bagalkote, Bangalore Urban, Belgaum, Bellary, Haveri, Davangere, Chitradurga, Tumkur, Raichur & Gadag) and Core groups in 9 other districts (Bangalore Rural, Chikballapur, Chamrajnagar, Dharwad, Gadag, Mysore, Kolar, Koppal, Shimoga)
2. JAAK North Karnataka Forum with the convening group (With its core group and alliances in North Karnataka Districts)
3. State JAAK Core Group : 12 members (including the Chair person and the ex-chairperson)

### **JAAK PANS PROCESS:**

**The Process:** JAAK PANS was conducted in two stages. The first part of PANS was organized on 26<sup>th</sup> August, 2010 at Haveri where District Forum members from 10 districts, representatives of the JAAK North Karnataka Forum and Core Committee members of JAAK participated. A total of 45 persons (24 males and 21 females) participated in the review. The representation was from 10 districts, 8 of which had intensively participated for 2 years in the process of public hearings and dialogue with the health authorities in the districts. The participants represented 23 key organizations in these districts. The second part of PANS was conducted at the state level meeting held on 15<sup>th</sup> -16<sup>th</sup> July 2011 where a total of 27 partner organizations participated along with representatives of the North Karnataka Forum and the state-level Core Committee. Of these 12 representatives had associated with JAAK for 5 or less than 5 years and 15 of them were associated with JAAK for more than 5 years. The questionnaire adapted from the national format was also sent by email and post to all the coordination committee members and core group members. The review was based on the processes and functioning of JAAK activists in the districts, responses received from member organizations by email or submission of the responses at the state level meet.

The issue of PANS was discussed at the state level core group and state committee meetings. A committee consisting of Dr. Prakash Rao, Akhila Vasan, Asha Killaru and E. Premdas was formed at the state core group meeting held on February 22, 2011 to take the process forward and to complete the same.

### **Methodology**



During Part I of the PANS was facilitated at the State level workshop at Haveri (Haveri District) on 26<sup>th</sup> August, 2010. There was a briefing on PANS and the participants worked in district-wise small groups and discussed the main themes in the questionnaire and made a district-wise presentation at the plenary. A plenary summarized these reflections. A SWOC (strength – weakness - Opportunity – Challenges) analysis was made of JAAK by the participants as an additional exercise with the entire group. This review was facilitated by Dr. Akhila Vasan, K. B. Obalesh and E. Premdas. (The notes on district presentations and the plenary is provided in Annexures 1 & 2 )

The main focus areas covered included the following:

- Overall experience of organizing public health action by way of public hearings, protests, dialogues in districts – positive experiences, challenges etc.
- Skills and strengths gained by the activists in the process
- Strategies that worked, did not work, and which backfired
- New friends / associates found. Good government officers, various movements which JAAK found in the process
- Gains for JAAK and changes that have happened (e.g. attitude and response to health dept, CEO and other public hearing.)
- Follow up done in districts and tasks at hand for the future.

In Part II of the PANS the questionnaire was administered to all the coordination committee members and networks by email and post and was also administered to the participating representatives from the organizations at the State level meet on 15<sup>th</sup> July, 2011 held in Bangalore and the analysis was then made and the key themes were integrated into this document. (The questionnaire is in annexure 3)

## **REFLECTION OF THE JOURNEY AND PROCESSES OF BEING PART OF THE HEALTH MOVEMENT IN THE STATE:**

Most of active JAAK members had got involved in the JAAK processes in the last 4-5 years (2006 onwards). Most of them expressed that the state-level public hearing that was organized by JAAK on 31<sup>st</sup> March 2009, in Bangalore (Town Hall) in which nearly 1500 people from 12 districts participated, generated a lot of interest and energy in them. The health activists then decided to take the public hearings to the districts and got interested in holding such similar processes. During the reflection activists from various districts shared their experiences, gave feedback on JAAK's strengths and the challenges that lay ahead.

***Sharing of experiences on Processes and Strategies:*** The JAAK activists come with their rich and diverse experience of working with various marginalized groups such as pourkarmikas, dalits, women, devadasis and with several years of experience on issues such as right to food, employment, education and other basic amenities. Exposure to health issues was new. As a result they reported that there was a lot of new learning about the systems, the gaps therein and tools and strategies they used in their work with the health system.

***Activities led by JAAK:*** Most of the participants in both the parts of review that they related to JAAK and health movement through activities which has community relevance and when they were led or facilitated by JAAK. This included a range of activities such participation in



trainings, surveys & documentation at the community level, public demonstrations and protests, public hearings, using RTI for health advocacy, processes of revitalizing PHCs and Taluka hospitals, right to primary health care campaigns etc.

**Public hearing:** One such strategy which found very useful was the public hearing. It had had a positive impact at many levels: They had been able to procure an identity for JAAK; they had been able to learn about the gaps in the system; public hearing had managed to mobilize attention for activists' demands from the administrators and finally in some cases it had been successful in seeking a response from the system in the form of a doctor's/ ANM's appointment, distribution of *madilu* kit (maternal kit), painting the list of services on the PHC wall along with PHC timings, staff, drug status and so on. Through the public hearing health activists were able to find new alliances, groups to work with at the local level. It had attracted media attention and support for the cause. Several districts had involved the gram panchayats and JAAK's manifesto and the cases of health care denials were taken up by the panchayats in the *gram sabha*. After the public hearing, even ASHAs had started contacting JAAK activists when they faced harassment from the administration. Of course there were some challenges as well. In one district after widespread media coverage about the upcoming public hearing, all invited government officials stayed away from the district headquarter on the pretext of some work or the other. Similarly not all local NGOs were supportive. There were many who had joined in the hope of finding some project. But when they found out that there were no funds they had dropped out.

**Use of RTI and filing complaints with the Lokayukta:** Apart from public hearing activists had understood how to use the RTI and used it to highlight gaps in the system such as vacancy position, drug supply at a PHC. They were also now familiar with the procedure of filing complaints with the lokayukta. They knew how to compile a case of denial/ death or discrimination.

**Right to Primary Health Campaign:** As part of the campaign, JAAK partners had undertaken monitoring the public health system through surveys of PHCs, initiating dialogue with the staff of the public health system at various levels and acting as a pressure group through various strategies:

- Mobilizing the community for collective action through public demonstrations, protests and rallies to demand their health entitlements on a range of issues such as availability of medicines, regularity of staff at sub-centres and PHCs, hygiene and upkeep of facilities and so on.
- Flooding the district administration with complaint letters. Some districts such as Bagalkote & Haveri, reported flooding the local administration with post cards complaining of various kinds of systemic problems in the health system. This strategy had also managed to grab attention of the local administrators and they had been willing to listen to the activists' demands and had assured them that action will be taken. In one instance letters about denial of health care were written to the health minister and the health commissioner. The former asked for immediate action and the latter has assured that strict action would be taken against the erring officials.
- Writing cases of health care denials, filing petitions, taking delegations to meet appropriate authorities and commissions, fact-finding reports and following up with SHRC and Lokayukta



- Using mainstream media (newspapers, TV, magazines, periodicals, journals): Press meets, press statements, articulating public health issues in the media, introducing health rights issues to journalists

**Publications in the local language:** JAAK partners had bought out publications in Kannada on health and human rights, health policy brief, introduction of PHM, JSA and JAAK, RPHC. These materials were distributed to all activists during various trainings at district and state-levels. JAAK also had translated into Kannada the five booklets prepared for the 1st PHA which has been used by the activists. The Kannada version of people's health charter (international and national) was a useful document, many felt.

**Publication of a quarterly newsletter:** JAAK partners by rotation have brought out four volumes of the quarterly newsletter which has facilitated learning across districts by highlighting the various activities undertaken. The newsletter also has a guest column where health rights issues of a marginalized community /group is discussed to facilitate greater understanding as well as ways to integrate those issues in the present campaigns.

**Developing alliance with other movements / campaigns:** Partners in JAAK are also part of many other networks and campaigns and have thus built strategic alliances with the state and national level networks and campaigns. Right to Food Campaign (RFC), Rural Workers' Union (GRAKOOS), Samaj Parivarthana Janaandolana (SPJ), Network for Bonded Labour Free Karnataka (Jeevika), Mahaadiga network, National Alliance of People's Movements (NAPM), People's Union for Civil Liberty (PUCL- K), Karnataka Rajya Raita Sangha (KRRS) at the district level and Dalit Sangharsh Samiti (DSS) are some of the prominent social movements in partnership with JAAK.

**Partner Organisations' Commitment to Health Rights & Equity:** Number of member organizations have supported and carried on the initiatives of right to health in their own way which has connected them to the JAAK activities. Many of them have continuously with their own initiatives have participated in the health dialogues, health monitoring, participated in public health programmes, participated in district and state level meetings etc.

## **STRENGTHS AND CHALLENGES**

### **Reflection on strengths**

The sharing led to the next step in the reflection process of understanding what JAAK's strengths are so far, how it needs to be consolidated, what challenges there are and how they need to be addressed.

***Identity as a health rights movement:*** The district forums of JAAK, through their work had managed to mobilize a lot of support from various local stakeholders such as the people, panchayats, NGOs/ CBOs and JAAK was becoming well-known as a health rights movement/ forum. Activists felt that this forum had the potential to be a truly people's movement. They had been able to mobilize people in communities through awareness that health was a human right. Many of them said that health rights issue was no longer a separate issue for them. They had a sense of ownership of the issue. They had managed to integrate it with their present work with communities. They felt they had a thorough grounding in basics of health rights. They felt that they were playing the role of a watchdog by keeping a constant



vigil on the administration. In fact their efforts had been paying off because the administration had been compelled to respond and address complaints and issues raised by JAAK.

**Structure and composition of JAAK:** Participants also identified some structural features in JAAK which they felt were unique and helped to sustain activities for the past 11 years. JAAK had been successful in bringing together diverse groups of individuals, organizations and collectives thereby strengthening its own capacity to straddle a range of issues and using a range of methods and strategies. For example, there are dalit activities, public health researchers, filmmakers all of whom bring in varied perspectives and skills enriching the health rights landscape. It had evolved a democratic model of functioning through participatory collective decision-making and team work. It had been successful in keeping a communication channel open through ongoing meetings, trainings and capacity-building. JAAK also had been able to build alliances and solidarity with other groups and networks and thereby mobilizing larger support for its work on health rights. Participants also reported feeling inspired by the presence of many committed individuals and the style of leadership demonstrated.

**Documentation and publication:** JAAK had demonstrated its strength through its excellent documentation of health rights issues in various forms (brochures, films and booklets). By this it had been successful in creatively engaging with the media to give visibility to health rights issues. Its publication in Kannada had enabled grassroots activists to access material on issues of health and human rights, political economy of health, globalization and health which otherwise were inaccessible.

**Capacity building:** JAAK had also richly invested in enhancing the capacity of grass roots level activists who now were key resource persons in their own districts on issues of health and health rights. They had been able to mobilize key materials, expertise and resources for their ongoing work and were driving the health rights campaigns in their districts with periodic support and inputs.

## Challenges

While JAAK had been successful in keeping the health rights movement on its track for over a decade, participants identified several challenges in its functioning.

**Network dynamics and administration:** Participants felt that all organizations / groups in JAAK do not work together with the same intensity. Eliciting participation and ownership by all members was seen as a challenge. They also felt that some groups do not necessarily endorse and practice JAAK's ethos and perspective on health rights which they felt needed to be addressed. Participants reflected on the nature of structure and leadership as practiced in JAAK. On one hand loose structure and diffused leadership had ensured flexibility in functioning and was able to take along several groups and organizations. But on the other hand it could also have cost the movement efficiency in functioning. For example, participants said that in the absence of a formal structure there were not sure who has to take the initiative to communicate and coordinate.

Participants felt that a balance needed to be struck to ensure democratic processes while having formal structures to enhance efficiency. Having fulltime persons committed to JAAK



work was seen as one way of ensuring efficiency. It would also perhaps facilitate a more coordinated, collective and sustained effort instead of working in fits and starts.

**Community presence :** While community has been involved its presence continued to be marginal. JAAK was yet to evolve into a large mass-based movement.

***Evolving a more comprehensive strategy to deal with problems in the health system:***

Participants felt that they needed more inputs and ideas on how to sustain and how to move ahead. For instance one area which the activists were interested in using judicial activism as it related to health. Participants reported feeling somewhat overwhelmed by the sheer enormity and multitude of issues to deal with in the health system. They were also wondering how adequate the rights approach was in dealing with deep-rooted issues of corruption, political interference, nexus with vested interests and so on.

**Meeting Expectations:** Number of partner organizations have expressed their expectations from the Central Leadership of JAAK in terms of providing timely and updated trainings & information, advocacay and financial support for activities on health rights, technical assistance and capacity building, support for cultural campaign, to build a cultural campaign group, to be a platform for the vulnerable groups, to build more karyakarthas etc. Most of the members have appreciated the support received for training and advocacy, to build karyakarthas with health perspectives. Some have also expressed that some of the expectations have not met.

**Financial and logistical support:** Number of members have expressed that they lack financial and human resource for working continuously on Health rights and also to participate in campaigns or to start cultural campaigns on their own. It was a common observation that most of the JAAK lead activists and partners come from small community level or community based organizations who have experienced the need for health advocacy in communities.

## **The Road ahead for JAAK (future)**

Some concrete suggestions came up from activists in terms of how to take the movement further and what the road map should look like:

### ***Strategic issues***

- Ensure centrality of community by starting at the grass root level. Encourage, motivate and inform the community workers to participate and contribute
- Involve younger activists in JAAK
- Connecting with other networks, movements at the state and district levels
- Bring the likeminded people and intellectuals to consolidate the JAAK activities for the movement
- Involve PRI
- Train the various committees that are part of the hospital/health set up on health rights – this will help identify, fix the health systems/ and other problems
- Redressal strategies to be strengthened: lobbying for Legal Compensations cases of health denials

- Mobilizing Information through RTI
- Become a state level pressure group

### *JAAK form, structure and capacity-building*

- Consolidate it at the state and at the zilla taluk level: Create a forum where the representatives at the Zilla Level are represented at the state level. There should be a representation at the state health sector from the taluk level
- Have an organization that can take up the “office”, structure at the Zilla level. This can be the focal point where organizations can go to this office/organization to take the movement further.
- Training in using technology to help in better communication, thus helping in the documentation/research and advocacy of the JAAK programs
- Immediate helpline for the health workers/activists of JAAK
- Encourage, train health activists in health protests/health movements that are needed to take up issues
- At the Zilla level, have a JAAK health activists as a fulltime resource
- Exposure visit/or learning for the health Activists

### *Building linkages with other people’s movements and campaigns and individuals*

Build strategic and working linkages with other movements and groups to be able to leverage enhanced support, collective action and improved outcomes of our action.

### *Content*

- A holistic and comprehensive method to look at the social determinants of health – employment, food security, housing, water, education
- Preventing privatizations of health care and regulation of the private health care sector

### *Human resources*

- Fulltime activists at district and state level are required
- Set up a media intervention unit for JAAK



## **Annexure 1 :**

### **The District-wise compilation of group responses and reflections on district processes of strengthening JAAK**

#### **The main focus areas covered are:**

- Overall experience of organizing and managing the public hearing – positive experiences, challenges etc.
- Skills and strengths gained.
- Strategies that worked, did not work, and which backfired.
- New friends / associates found. Good government officers, dalith movement
- Gains for JAAK and changes that have happened: attitude and response to health dept, CEO and other public hearing.
- Follow up done in districts and tasks at hand.

#### **District – wise presentation of the Group Discussion:**

##### **1.District: CHITRADURGA,**

##### **1. Public hearing Public dialogue, process, success, and challenges:**

- Energy and the positive attitude to take this. The public consultation has brought a lot of NGOs together
- There is a doc who has been appointed
- The PHCs and the health units are clean and functioning better
- There is an awareness, and the JJK work is known now in the district.
- The DHO now personally goes to the health systems to visit and has his own fact finding on how things are being run in the units.

##### **2. What skills and strengths you gained. Those aspects that increased your confidence:**

- Worked on the areas of women and children.
- The people and the officials have come to know JAAK and health movement
- The public now know that this movement is alive. The zilla/district, the establishment and us have been able to know about each other through the processes of JAAK. There is a lot of learning that we got from JAAK in the course of orientation, trainings, press conferences and interaction with state conveners.

##### **3 What are the strategies employed? What worked? What did not work**

- Case studies: we studied PHC/CHC and sub- health centers. We have documented the denial cases , and also have tried to handle the issues.
- There were a lot of documentation that supported our claims and demands which was very useful. This is a new strategy that we have practiced.

- Networking / Coming together: In Chitadurga at the Panchayath level self help groups, and other NGOs have come together for these programs and to address health issues.
- Memoranda and consistent demand raising: We have submitted a detailed report to them – on the issues that were raised at the public hearing. This forced the administration – the jilla panchayath, DHO - to take immediate action. The DHO spoke to the doctors, and have taken the necessary action. The DHO has also spoken to the victims.
- The PHCs have seen improved cleanliness, presence of doctors and the availability of medicines has increased.
- Due to the collective pressure the DHO is now exceptionally cooperative

The concerns:

- The public needed additional training on the way to handle the public hearing. There was a need to have more time to consolidate the processes and then implement it
- the lack of time also was a limitation for thorough fact finding on some of the cases.

4. New friends/associates found, processes of good governance found, gov officer, movements that supported the movement:

- Self help groups and their members
- The jilla panchayath members and the people.
- The health officials were cooperative, despite all the slogan shouting's with them.
- The local press : Journalists covered the rally and the issues well. They were also sensitized. They are our new allies.

5 Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing

- Jilla panchayath and the family welfare have become more cooperative with JAAK activists. They are now aware of all the concerns. They are now responsive to our needs to address the issues of the health system.
- The two, three PHC has got special attention – as these three PHCs were taken for this consultations. Now the DHO would make an effort to look at the other health Units in the PHC. The response of the DHO has managed to get the vacant positions fixed.
- the procession that was taken through the district and this caused a lot of public awareness, despite the rain the procession took place in the front of the DHO's office. This has led to a lot of confidence in the JAAK movement and has motivated us to take this to the next level.
- The one week of intensive effort got us our "identity" – the district JAAK workers have got an identity.

6 . Follow-up done in the districts and tasks at hand.

- post the public consultations – need to work closely with the administration



- meeting with the health officials are going on

## 2. District BELLARI.

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### 1. Public hearing Public dialogue, process, success, and challenges:

- The process was new personal learning
- has helped us with understanding RTI – when we decided to take up the public hearing, RTI process was taken up and there were many oppositions.
- Some NGOs did not participate into this public hearing, because they would not get projects.
- when they say JAAK, they wanted ID proof. We needed to argue with them to get information.

### 2. What skills and strengths you gained. Those aspects that increased your confidence:

- RTI and the drafting of RTI; Some of the issues on health got realized through the RTI (For example, water facilities that are provided)
- talking to the taluka health officers and elected member on health

### 3 What are the health strategies' employed? What worked? What did not work

- RTI, and constant meeting with gov officials.
- looking at and documenting the patients health rights violations, and understanding their problems
- What did not work was that when we conducted the public hearing, some of the the gov officials did not come and some patients too were hesitating to speak due to the fear.

### 4. New friends/associates found, processes of good governance found, gov officer, movements that supported the movement:

- Some new NGOs (Vahini, Donbosco) joined JAAK
- Press and the media

### 5 Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing

- The JAAK is a state level movement – so the local administration is looking at this seriously
- The officials are now serious about our delegations and memoranda.
- there is a lokayuktha officer who has been part of the campaign. He has been of great support should there be a corruption issue, we will be able to plug the loopholes.
- **there is a greater awareness with the people and other NGOs about JAAK in the area.**

### 6 follow-up done in the districts and tasks at hand.

- work on health through RTI continues
- if there are health violations and corruptions we are sending the complaints to the

#### Lokayutha

- protest through mails /letter campaign continues
- there are changes seen at the PHC levels where we have intervened: a medical officer and trained nurses for the testing of HIV have been appointed in Mariammanahalli PHC
- Due to the pressure through RTI, the doctor trained in RTI has been appointed to his post.

#### Other Observations:

- need to look at the methods to involve the lokayuktha more effectively.

### 3. District: BAGALKOT,

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#### 1. Public hearing Public dialogue, process, success, and challenges:

- conducted a public hearing – has raised public awareness.
- the conflicts between NGOs and the lack of involvement to get other groups together for a common cause is a major challenge.
- this was the first time that a forum like JAAK could question the authorities on health
- there was a serious health denial case of a PLHIV. The KHPT office bearers wanted to hush up the issue in the public hearing and tried to disrupt the programme.
- The media support was strong, that this was covered very well. There has been a lot of awareness on this.

#### 2. What skills and strengths you gained. Those aspects that increased your confidence:

- collating data, and the survey documentation
- reporting
- case study as a method – not too many people did know how to work on a case study. There was training to document cases.
- The process of submitting memoranda, letter campaign and sending to the gov officials in writing has been followed by many activists as part of this process.

#### 3 What are the health strategies employed? What worked? What did not work?

- media has worked well with us. There has been a good coverage in the media.
- the press meet a couple of days before announcing the public hearing back fired, as it got a wide coverage. On the day of the public meeting the gov officials absconded.
- insisting on citizen charter in PHCs
- people have recognized the need of health rights and the need to voice their concern.

#### 4. New friends/associates found, processes of good governance found, gov officer, movements that supported the movement,

- women's organizations, farmers organizations and Dalit organizations have been very strongly supporting JAAK.



5 Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing

- There is support from the jilla panchayath.

6 follow-up done in the districts and tasks at hand.

-to send communiqué to the CHO, DHO on the issues of health centres.

- the health staff have now involved the JAAK members in their visits to centres
  - need to get the press meet to discuss the follow up on the action items of the consultations.
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- Sub centers are in a bad state.
- doctors don't treat if the patient is HIV
- need to have identity card for the members of JAAK – this is one way to get the work done by the activists.

#### 4. District: RAICHUR,

1. Public action & dialogue, process, success, and challenges:

- in the public hearing – there were a couple of cases where the ASHA worker was beaten by the staff nurse. She was questioned and bullied by the administrative authorities later.
- There was no real format to collate data. This also hampered the collating of the data – even though we had managed to survey many PHCs

2. What skills and strengths you gained. Those aspects that increased your confidence:

- skill of networking around health and health rights.

3 What are the health strategies' employed? What worked? What did not work?

- Bringing together several ngos, and also eminent people
- collective meeting with the health officials

4. New friends/associates found, processes of good governance found, gov officer, movements that supported the movement,

There was cooperation from many quarters

5 Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing

- There is change in the health centres and sub-centres
  - JAAK is now a name here – and they are all looked up with seriousness
  - the DHO is now very supportive
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## **5. District: DAVANGERE.**

### **1. Public hearing Public dialogue, process, success, and challenges:**

- in 2007 we had received training on the JAAK, but now recently it has gained some momentum.
- we have been able to work k with many NGOs – SWEAT, vani mahila madla, and 6 other organizations
- Through the public hearing we got a lot of support from the community
- Working with the district administration and Panchayat is a challenge;

### **2. What skills and strengths you gained. Those aspects that increased your confidence:**

- formerly, we would work in other areas but not in health. But now we have been working in the area of health and are able to look at the various indicators of health. This has benefited many people and has given us a sense of direction in work
- there are many NGOs who are getting involved and are willing to join with JAAK
- this needs more honing of skills. There is a requirement for additional trainings.

### **3. What are the health strategies' employed? What worked? What did not work?**

- JAAK's manifesto has been taken to many villages – and many members have taken notice in the gram panchayath.
- looked at the situations on water and hygiene
- Mass awareness on NRHM and Community Participation : now the community know what are the facilities that are provided in the aganwadi, in phcs, and what is the roles of the ASHA and ANM.
- Today the ASHAs contact us if they encounter any trouble and harassment
- We have worked with the NREGA.

### **4. New friends associates found, processes of good governance found, gov officer, movement that supported the movement,**

- the DC is very cooperative with the JAAK activities.
- new press persons have become friends of JAAK
- there is a periodic follow-up now with the PHCs
- the jilla samithi of JAAK is quite active
- there is cooperation by other NGOS who are willing to join hands with JAAK

### **5 Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing**

### **6 Follow-up done in the districts and tasks at hand.**

- meetings and discussion with the district committee of JAAK



- meetings with DHO, DPMO

## 6. District TUMKUR,

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### 1. Public hearing Public dialogue, process, success, and challenges:

- learnt about the poor functioning of the PHC and sub-centres
- understood the dynamics of the relationships of the doctors with the patients
- learnt about the various denials of health rights – be it maternal care, 24/7 functions, personnel needed to run the PHC, taluk hospitals
- ensuring that the maternal kits and facilities are provided to the mother
- soon after the public hearing, wrote complaint letters to the health minister and the health commissioner. The health minister has asked for immediate action, the health commissioner has ensured that there would be strict action taken with failing health officials, wherever there has been health denials. This is going on.
- NRHM and its financial allocation, that is being studied
- Pavagadha gets a financial and developmental package for the naxal affected people and the package does not reach the people. This needs to be looked at by JAAK
- the documentation of all the health violations, chloride water problem, aganwadi services has to be followed up

### 2. What skills and strengths you gained. Those aspects that increased your confidence:

- skills of documentation, informed discussion with the medical officers/DHO

### 3 What are the health strategies' employed? What worked? What did not work

- organizing public hearings, press conferences, mobilizing communities

### 4. New friends/associates found, processes of good governance found, gov officer, movements that supported the movement,

- gov officials, dalith organizations, DSA, SPJ, other likeminded people, and others in the civil administration

### 5. Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing

- In the taluk they have seen the work of the JAAK and now know the work JAAK does
- Have taken measures to fix some problems in the the system
- Reporting health rights violations to the human rights and lokayuktha

### 6. follow-up done in the districts and tasks at hand.

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The concerns of the manual scavengers has been taken up. There is a constant follow-up

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## 7. District: BELGAUM

### 1. Public hearing Public dialogue, process, success, and challenges:

- surveyed 10 PHCs
- worked with the villagers, and the lack of information that they had about NRHM and health system was communicated to them
- the corruption and lack of functioning of the civil administration was a challenge
- looked at several delivery cases in the PHCs, and now this has declined
- the panchayath has now in taken up these responsibilities at the gram sabha, and they know that this is an important aspect that they need to follow. The panchayath members were also trained on the issues of health system
- the PHCs now have all the services that are provided, and it is written on the PHC wall
- took up the issue of PDS and food security as part of the public hearing

### 2. What skills and strengths you gained. Those aspects that increased your confidence:

- training skill: have trained people from all sections of the society
- Usage of RTI in health
- developed a film Gunamukhi

### 3 What are the health strategies' employed? What worked? What did not work?

- organizing the public
- training on health to the Gram Panchayath members
- training skills
- ensuring that people learnt to question the dis-functioning of the system, and encouraging them to write letters of protests

### 4. New friends/associates found, processes of good governance found, gov officer, movements that supported the movement,

- several NGOS,
- The aganwadi workers are all working well with us.

### 5 Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing

- There are a lot of changes in the infrastructure, water, electricity, institutional delivery, entitlements are given to the mothers,
- there is an attempt to curb corruption where the DHO has issued letters to each PHCs.
- The gram Panchayat is now looking and discussing with the doctors and health workers on their functioning
- Hope of finding some solution to the problems faced by the victims of the health denials

### 6. follow-up done in the districts and tasks at hand.

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- continuing to work with the administration and continue to impact change
  - need to work extensively on the follow-ups
  - there is often a coordination problem with several NGOS - and when there is a public consultation, one does not get their support, as they are involved in their own work.
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## **8. District: Haveri**

### **1. Public hearing Public dialogue, process, success, and challenges:**

- in the public hearing these were topics that were raised: discrimination on the part of the doctor against the poor patients, caste discrimination etc. These were the first of its kind
- no knowledge on the PHC roles and functioning was a challenge which we started addressing
- the PHCs are far away from the village, accessibility to the PHC is a constraint
- the drugs unavailability

### **2. What skills and strengths you gained. Those aspects that increased your confidence:**

- RTI information the doctor denied a lot of information and this was sort out from RTI
- DPMO and DHO – had several discussions with them.
- Compiled a small handbook on health issues
- DHO asked 12 PHC doctors to come and to explain the complaint on denial cases.
- after the public consultation, they have now started distributed the madilu kit to the mothers.
- presented 10 case studies
- demand to give compensation of 20, 000 in cases of two serious cases of denial

### **3 What are the health strategies' employed? What worked? What did not work**

- have sent 200 letters on various issues to DHO
- RTI
- documentation of the status of health institutions and on cases of negligence
- public hearing and dialogues

### **4. New friends/associates found,**

- In the processes we have found good officers
- have discovered other small social movements that supported the JAAK movement,

### **5 Gains for JAAK. Changes that happened – in attitude and response of health dept and public hearing**

## Annexure 2:

### General observations by the facilitators on the discussions and presentation by the district groups made at plenary

1. All the 8 districts have the presence of JAAK
2. People are talking about health rights and are raising their voices
3. There is a systematic way of documentation and inquiry which is adopted as strategy
4. The issues of health violations is one and along with that those aspects of the health systems are being tackled – as this is the sure way to consolidate and strengthen the health system
5. Documentation and its importance of recording each of the data and facts show that there is proof to our work and to the work that needs to be done
6. For Bellari, they have taken the RTI strategy to get their work done – this way there are several questions and methods that are being involved to tackle the problems such as using the media to solve our problem, or other strategies
7. How does one try to consolidate the movement? – it is important to ascertain the strengths, understand the weakness and also know how much can be achieved to getting this movement momentum.

(Every participant wrote about the strength and challenges of JAAK as a whole)

#### Strength:

- to bring several NGO's together, bringing documentation and research together; JAAK communicates the health rights to the people, State level union, taken on the responsibility of the state and have asked the government to raise to the needs of the people; a people's movement; people have known their rights, constant vigilance to the administration; the strength of the people; realizes that health rights is human rights too; brought about a unity with people, positive thinking and perspective, leadership, awareness, to question, bringing the youth together ; the thought that this is our problem, the sense of ownership; self belief and the belief to fight and face the challenges, and human empathy; public approval; developed health rights activists;
- The most number of responses has been that this is a people's movement, and that the state has now been compelled to look at the health systems and JAAK is now the watch dog to the government.
- The feeling of owning up to this movement as "mine" is the unique aspect of this JAAK movement.

#### Weakness' and Challenges:

Organizations don't work together with the same intensity; the community needs more health awareness; the support of people is less; the need for peoples participation, lack of training on health rights for health workers; lack of leadership ; sustainability; lack of financial support to victims; lack of motivation; lack of communication; limited approach to only health service; the knowledge of the law and judicial activism on health; corruption in all aspects of health; the peoples movement is not against the government, this needs to be balanced. People don't get to activism and participate in movements.



**The Road Head for JAAK: Action Items and Vision to take the movement further:**  
Each participant again wrote about way to take movement forward.

1. Take the movement at the grass root level, community
2. Encourage, motivate and inform the community workers
3. Build and consolidate the organization – JAAK
4. Consolidate it at the state and at the zilla/taluk level
5. Create a forum where the representatives at the Zilla Level are represented at the state level. There should be a representation at the state health sector from the taluk level
6. Immediate helpline for the health workers/activists of JAAK
7. Training in using technology to help in better communication, thus helping in the documentation/research and advocacy of the JAAK programs
8. Involve the youth in the JAAK programs
9. Follow-up on each of the denial cases
10. Constant spreading of the JAAK messages on health rights at all levels.
11. Tie up and bridge the network with several state level organizations and movement
12. A holistic and comprehensive method to look at the social determinants of health – housing, water, education, etc. is an added Responsibility to each health activists
13. Involve and evolve new strategies like RTI/protests through letters, emails/
14. Involve the administration in the JAAK missions
15. Bring the likeminded people and intellects to consolidate the JAAK activities for the movement
16. Encourage, train health activists in health protests/health movements that are needed to take up issues
17. Have an organization that can take up the “office”, structure at the Zilla level. This can be the focal point where organizations can go to this office/organization to take the movement further.
18. Involve PRI in all the discussions with JAAK
19. Train the various committees that are part of the hospital/health set up on health rights – this will help identify, fix the health systems/ and other problems
20. At the Zilla level, have a JAAK health activists as a fulltime resource
21. Exposure visit/or learning for the health Activists
22. Questioning the privatizations of health care, and involve a strategy to help in regulation of health care sector.

### **Annexure 3:**

#### **JANA AROGYA ANDOLANA KARNATAKA (JAAK)**

#### **PARTICIPATORY ASSESSMENT FOR NETWORK STRENGTHENING**

1. Name: \_\_\_\_\_

2. Organisation: \_\_\_\_\_

3. For how long have you /your organisation been associated with JAAK?

\_\_\_\_\_ years/ \_\_\_\_\_ months

**Participation:**

4. What kinds of activities of JAAK have you/ your organisation been actively involved in?
5. What activities has your organisation done as part of JAAK/as contribution to the health movement in Karnataka/People's Charter for Health?

**Expectations:**

6. what were your /your organisations' expectations for JAAK?
7. Which of these expectations have been met?
8. Which of these have not been met and why?

**Strengths/Challenges:**

9. If you were to list three most important strengths of JAAK what would they be?
10. What do you think are its three most important weaknesses?
11. How do you think they should be addressed?

**On strategies:**

12. What strategies do you think have worked well for JAAK to strengthen health movement and to address health rights issues? How do you suggest they be strengthened?
13. What strategies need strengthening and how?
14. What strategies would you suggest JAAK adopt vis a vis the following groups:
  - 14a. To strengthen people's participation in the movement
  - 14b. JAAK's position vis a vis the government
  - 14c. To strengthen its linkages with other movements

**Future Thrust:**

15. What are the three core areas where you feel JAAK should focus on/ intensify its work on in the coming years?



16. What are your suggestions and methods for JAAK to address these?

17. Would you suggest any other group/people's movement/organization/individual that you know, could join JAAK?

Annexure 4: Activity and events list of JAAK (2000-2011)

Annexure 5: Compilation of Responses from the State level organizations

Annexure 6: List of Organisations/networks, Districts Forums and JAAK North Karnataka Forum





# JANAAROGAYA ANDOLANA KARNATAKA – (JAAK) –

## Summary of PPT by Obalesha on PANS process

(on behalf of JAAK Core Group).

1. Short overview of Karnataka – People and Health
2. JAAK participating organizations and networks (2000-2011)

### a) State level networks /units of national networks :

All India Janvadi Mahila Sanghatane (AIDWA); Bharat Gyan Vigyan Samithi (BGVS)  
Community Health Cell (CHC); Catholic Health Association of Karnataka (CHA-Ka)  
Christian Medical Association of India (CMAI); Drug Action Forum –Karnataka (DAF-K); Joint Women's  
Programme (JWP); Karnataka State Medical & Sales ; Representatives Association (KSMSRA) ; National  
Alliance of Women (NAWO) Voluntary Health Association of Karnataka(VHAK); NAPM – Karnataka

### b) Other state networks – included initially

NESA , SOSWA, KPRS ( Raitha Sangha) , KRVP ( Vigyan Parishad) ., Foundation for Revitalization of  
Local Health Traditions (FRLHT); Family Planning Association of India ; (FPAI) Mahila Samakhya  
Karnataka (MSK);

### c) Newer networks and organizations in recent years.

Basic Needs India(BNI) ; Dalit Human Rights Organisation (DHRO) ; CBR Forum (CBRF) ; Karnataka  
Kolegeri Nivasigala Samyuktha Sanghatane (KKNSS) ; Right to Food campaign ; Samajaparivartana  
Janaandolana (SPJ) ; GRAKOOS ; Karnataka Sexual Minorities Forum ; Mahaadiga Karnataka  
Indian Social Institute; Jeevika

## 3. Phase – I (2000-2005) : Formative years.

- ❖ Campaign materials for mobilization – five booklets and Kalajatha book
- ❖ State health assembly, Davangere Nov 2000
- ❖ Participation in Jan Swasthya Sabha, Kolkatta – 2000 (137 Participants)
- ❖ Participation in first People's Health Assembly, Savar Bangladesh.2000 ( 14 delegates)
- ❖ People's Health Day launched – 7<sup>th</sup> April 2001
- ❖ People's Health Dialogue and Participatory workshop 2002
- ❖ Various campaigns and meetings related to national and state issues
- ❖ Urban Public Hearing on denials of Right to Health Care, Koramangala( NHRC) campaign- 2004
- ❖ Participation in Regional Public Hearing , Chennai 2004
- ❖ 2<sup>nd</sup> Karnataka State People's Health Assembly – July 2005
- ❖ Participation in 2<sup>nd</sup> National Health Assembly, 2007

## 4. Phase – II : Right to Primary Health Care campaign 2006 - 2011

- April 25, 2006 State level review meet - Everyone pledged that PHCs should be revitalised and the result: RIGHT TO PRIMARY HEALTHCARE CAMPAIGN
- 93 PHCs surveyed – in 12 districts (2006)
- Dialogue with the Health system to revitalise PHCs
- Occasions to train people on RTH perspectives
- Organised people – occasion to strengthen PHM through awareness campaigns
- Dialogue with the local health officers, signature campaigns, letter campaigns
- 1<sup>st</sup> February 2007, State wide action in 17 districts – mass petitions to demand healthy health system.
- Oct/Nov 2007, Health Rights Day and Dialogue with Director of State Health Services.
- Process continues with action and dialogue.

## 5. Additional events /activities

- Strengthening JAAK and building health activists in districts
- Preparation of materials on PHC and Right to Health in Kannada.
- Training to numerous organizations in Right to Health Care

Karnataka.

Presentation

(4a)

- Constant mobilizing and energizing at district level through linkages with movements, collectives and CBO's
- Engagement with NRHM at state level
- Electoral advocacy in 2008 for National Health Bill – health policy bill
- Advocacy extended to candidates participating in GP and BBMP elections
- Health Policy brief.
- Roping in lokayukta for denial and discrimination in health system ( 24\* 7 helpline )
- State level public hearing in March 2009.
- District public hearings being planned.
- Creating space for dalit voices
- Integration of marginalized communities in RTHC since 2008

#### 6. PANS review conducted in two parts:

- a) The 1st part was organized on 26th August, 2010 at Haveri:
  - 45 District Forum members representing 23 organisations from 10 districts
  - Representatives of the JAAK North Karnataka Forum
  - Core Committee members of JAAK participated
- b) The 2nd part was conducted at the state level meeting (15th -16th July 2011)  
27 partner organizations participated along with representatives of the North Karnataka Forum and the state-level Core Committee
- c) Methodology: A questionnaire was developed which each partner organization filled in separately
- d) This was followed by small group discussion in district-wise groups and focused on:
  - Skills and strengths gained by the activists in the process ; strategies that worked, did not work ; new friends / associates found; gains for JAAK and changes that have happened; follow up done in districts; tasks at hand for the future
- e) Prepared report with appendices on feedback about JAAK's present strengths, weaknesses, opportunities and challenges

#### 7. JAAK Strengths

- Identity as a health rights movement
  - Through various health actions, districts forums were now well-known
  - Health rights – no longer a separate stand-alone issue
  - Administration had to sit and respond to issues raised by JAAK
- Structure and composition of JAAK
  - All partners contribute in the spirit of volunteerism
  - Democratic model of functioning through participatory collective decision-making and team work
  - Diverse composition with varied perspectives and skills enriching the health rights landscape
  - Built solidarity with other movements and thereby mobilizing larger support for its work on health rights

#### Documentation and publication:

- Brochures, films and booklets on health rights issues
- Quarterly Newsletter
- Publications in Kannada had ensured grassroots activists' access to issues of health and human rights, political economy of health, globalization



- **Capacity building**
  - JAAK had enhanced activists' capacity to lead health actions independently
  - Developed a curriculum on HHR trainings
- **Media intervention at district and state levels**
  - Articles in local and state level newspapers
  - Increasing visibility of JAAK work in the media

## 8. JAAK Challenges:

- Network dynamics and administration
  - All groups in JAAK do not work together with the same intensity
  - All groups do not necessarily endorse JAAK's ethos and perspective
  - Communication and coordination needs to be more efficient
- No sustained monetary support for activities
- Community presence needs to improve
- Evolving a more comprehensive strategy to deal with problems in the health system: Adequacy of rights approach?
- Need to strengthen links with other state PHMs and with JSA

## 9. Road Ahead for JAAK

### a) *Strategic issues*

- Ensure centrality of community by starting at the grass root level.
- Connecting with other networks, movements at the state and district levels
- Involve PRI
- Train the various committees that are part of the hospital/health set up on health rights
- Redressal strategies to be strengthened: lobbying for Legal Compensations in cases of health denials
- Mobilizing Information through RTI

### b) **JAAK form, structure and capacity-building**

- Consolidate it at the state and at the zilla/taluk level
- Representatives from district to be at the state core committee.
- Have an organization that can take up the "office", structure at the district level.
- Training in using technology to help in better communication, documentation/research
- Immediate helpline for the health workers/activists of JAAK
- Need fulltime activists for JAAK
- Exposure visit/or learning for health Activists

### c) **Set up a media intervention unit for JAAK**

### d) **Thematic issues:**

- A comprehensive way to look at the social determinants of health – employment, food security, housing, water, education
- Preventing privatization of health care and
- Regulation of the private health care sector


**HEALTH FOR ALL ATLEAST – NOW!!!**





# JANAAROGYA ANDOLANA KARNATAKA (JAAK)

Report  
JAAK Core Group



JSA-NCC Meeting  
Nagpur  
10<sup>th</sup> -12<sup>th</sup> November 2011

# KARNATAKA- PEOPLE & HEALTH

- Area :1,91,791 sq.km.
- Karnataka Population: 6.8 crore (68 million)
- Urban Population 33.98%
- Rural Population 66.01%
- Sex Ratio 964 females per 1,000 males

**Health Services**

- Subcentres: 8143
- Primary Health Centres (PHC): 1676 + 9 (urban)
- Community Health Centres (CHC): 249
- Primary Health Units (PHU): 583
- 22,000 practicing doctors in the State
- bed strength 43,479

# JAAK - PARTICIPATING ORGANISATIONS AND NETWORKS

- All India Janvadi Mahila Sanghatane (AIJMA)
- Bharat Gyan Vigyan Samithi (BGVS)
- Community Health Cell (CHC)
- Catholic Health Association of Karnataka (CHA-Ka)
- Christian Medical Association of India (CMAI)
- Drug Action Forum -Karnataka (DAF-K)
- Joint Women's Programme (JWP)
- Karnataka State Medical & Sales Representatives Association (KSMSRA)
- National Alliance of Women (NAWO)
- Karnataka Health Association of Karnataka (VHAK)
- NES, SOSWA, KPRS, KRVP
- Foundation for Revitalization of Local Health Traditions (FRLHT)
- Family Planning Association of India (FPAI)
- Mahila Samakhyas -Karnataka (MSK)
- Basic Needs India(BNI)
- Dalit Human Rights Organisation (DHRO)
- CBR Forum (CBRF)
- Karnataka Kolegeri Nivasi Gala Samyuktha Sanghatane (KKNSS)
- Right to Food campaign
- Samajaparivartana Janaandolana (SPJ)
- GRAKOOS
- Karnataka Sexual Minorities Forum
- Mahaadiga Karnataka
- Indian Social Institute
- Jeevika

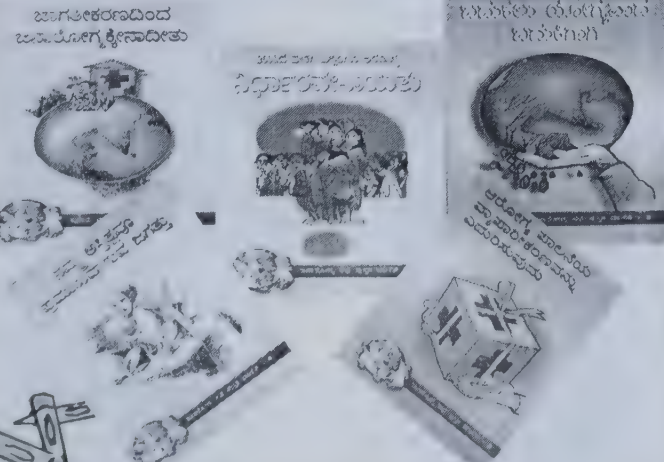
12+11+12

# Phase - I : 2000-2005 Formative Years

# Phase - II : 2006-2011 Collective Campaigning

# PANS Process Report

# Campaign Materials for Mobilization



# Karnataka State Health Assembly - I

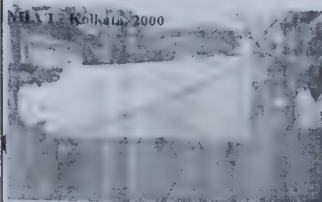
# Davanagere, November 2000







## Jan Swasthya Sabha, Kolkata 2000



- Over 2000 participants
- Mobilization across 19 states
- Adopted 20 point Indian People's Charter
- Launched the Jan Swasthya Abhiyan, campaigning for
  - Health for All Now
  - Health as a Fundamental Human Right

## FROM DAVANAGERE TO KOLKATA - THE JOURNEY SO FAR....

Participation in 1<sup>st</sup> National Health Assembly (Jan Swasthya Sabha) in Kolkata, 30<sup>th</sup> Nov to 2<sup>nd</sup> Dec 2000



Kolkata (2000)  
Delegates 137

## FROM DAVANAGERE TO SAVAR - THE JOURNEY SO FAR....

Participation in 1<sup>st</sup> People's Health Assembly Savar, Bangladesh- 4<sup>th</sup> to 8<sup>th</sup> Dec 2000

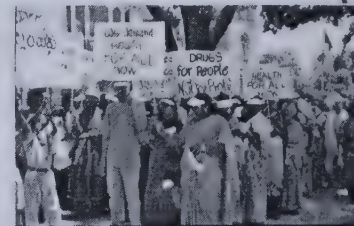
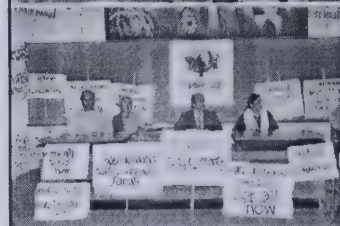


Savar (2000)  
Delegates 14

## Campaigns and Strategies Campaign on Health as a Human Right



People's Health Day  
7<sup>th</sup> April 2001  
Bangalore

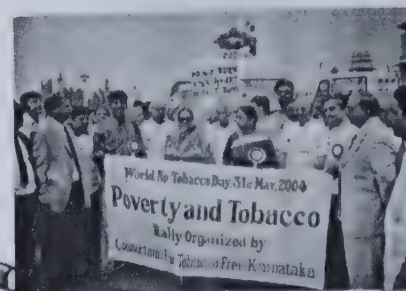


## JANAAROGYA ANDOLANA- THE BEGINNING People's Health Dialogue and preparatory Workshop -2002



## VARIOUS CAMPAIGNS

### CELEBRATION OF PEOPLE'S HEALTH DAY



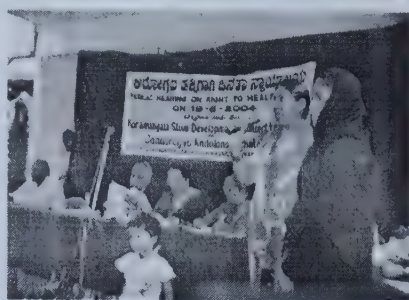
APRIL 7TH 2004 &  
ANNUALLY THEREAFTER





## Urban Public Hearing ( NHRC Campaign) -slum dwellers at a public hearing on right to health, Koramangala - 2004

Access to  
essential drugs,  
right to food,  
right to health.....



## FROM DAVANAGERE TO BANGALORE - THE JOURNEY SO FAR...

2nd KARNATAKA STATE PEOPLE'S HEALTH ASSEMBLY



BANGALORE  
7th JULY 2005

## JAAK -RIGHT TO PRIMARY HEALTH CARE CAMPAIGNS (2006 -2007)



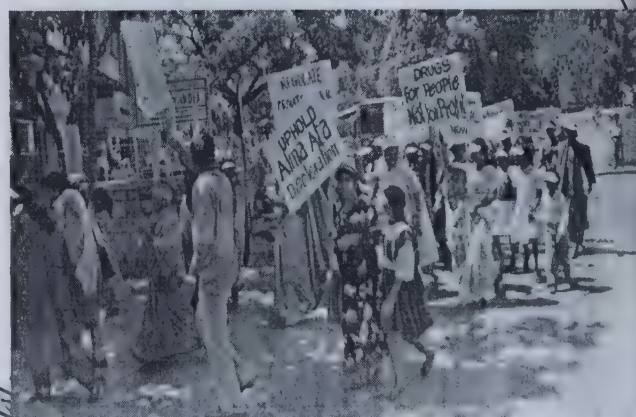
## The Process of the Campaign

- April 6, 2006 – World Health Day Dialogue failed
- April 25, 2006 State level review meet - Everyone pledged that PHCs should be revitalised
- And the result: **RIGHT TO PRIMARY HEALTHCARE CAMPAIGN**
- Anger at the apathy of the government official was turned into mobilisation
- **HEALTH IS OUR FUNDAMENTAL HUMAN RIGHT** was the slogan

## Right to Primary Healthcare Campaign

- People's health campaign: campaign to revitalize PHCs
- 93 PHCs surveyed - in 12 districts (2006)
- Dialogue with the Health system to revitalise PHCs
- Occasion to train people on RTH perspectives
- Organised people - occasion to strengthen PHM
- Awareness campaigns
- Dialogue with the local health officers, Signature campaigns, letter campaigns

## Demanding Right to Health /Healthcare...







## PHC at Haveri, Karnataka (2007)

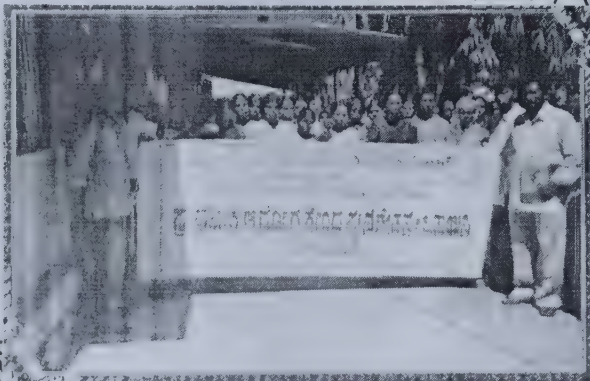


## Findings of survey - Diseases affecting PHCs

- Severe staff shortage (doctor, nurse, other health human resources)
- Under-funded health system - shortage of essential medicines, equipments)
- Poor or absent infrastructure (water, toilets, electricity etc.)
- Rampant corruption
- Irrational geographical distribution of PHCs
- No basic facilities to the Health Staff
- Neglect by the Government - lack of political will
- Lack of awareness among people about health rights

FAILING, UNATTENDED, NEGLECTED PUBLIC HEALTH SYSTEM.. Required diagnosis and treatment

## RPHCC - Demanding Health Rights Statewide Action in 17 districts - Feb.1, 2007



## Demanding Health Rights 29<sup>th</sup> Oct 2007

- 17 districts of Karnataka
- Mass action and Mass petition to demand healthy health system
- JAAK delegation dialogues with the Director of State Health Services on 12<sup>th</sup> November, 2007

## Health Rights Day 29 Oct 2007



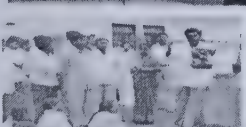
## Health Rights Day 29 Oct 2007







## JAAK - CAMPAIGNS RIGHT TO PRIMARY HEALTH CARE



## Outputs of the Campaign

- 18 districts meetings and trainings
- Number of booklets, pamphlets prepared
- State level planning and review meeting - every 2 months
- 85 activists underwent 2 day training on HHR (Dec 17-18, 2006)
- Preparation of a right to health songs CD (sung by PHM partners)

## Learnings and key decisions...

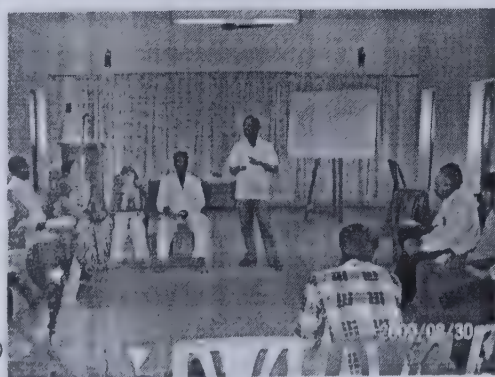
- Strengthening District Level RTH Forum through JAAK - district level health workshops, trainings
- Preparation on materials on PHC and Right to Health in Kannada
- Trainings to numerous organisations on RTHC
- Constant mobilizing and energizing at the district levels through linkages with the various people's movements, collectives and CBOs

## Strengthening JAA-K: Building Health Activists in District

- 2 day workshops for health activists in 9 districts
- 450 health activists trained
- 10 state level workshops held



## District Capacity Building



## Making National Rural Health Mission work September 4, 2007 - workshop by JAAK







## Electoral advocacy in 2008 for National Health Bill



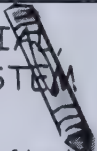

- JAAK prepared health policy brief
- Context of state elections
- Met contesting candidates to put health on their electoral campaigns
- Issues raised in the policy brief discussed in the Legislative assembly
- Advocacy extended to candidates participating in GP and BBMP elections
- To add health issues in their manifestos

- 



# ROPING IN LOKAYUKTA FOR DENIAL DISCRIMINATION IN HEALTH SYSTEM

- 24x7 helpline of lokayukta
- Formal complaint forms are circulated on denial of health care and corruption



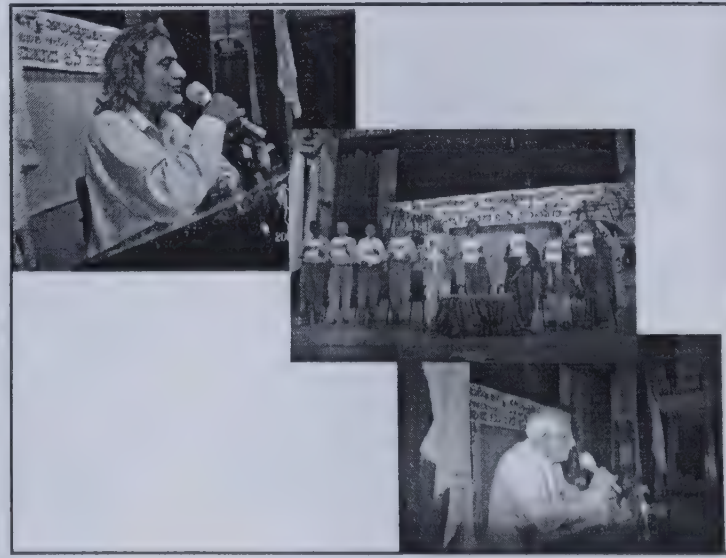
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# STATE LEVEL PUBLIC HEARING 31-03-09

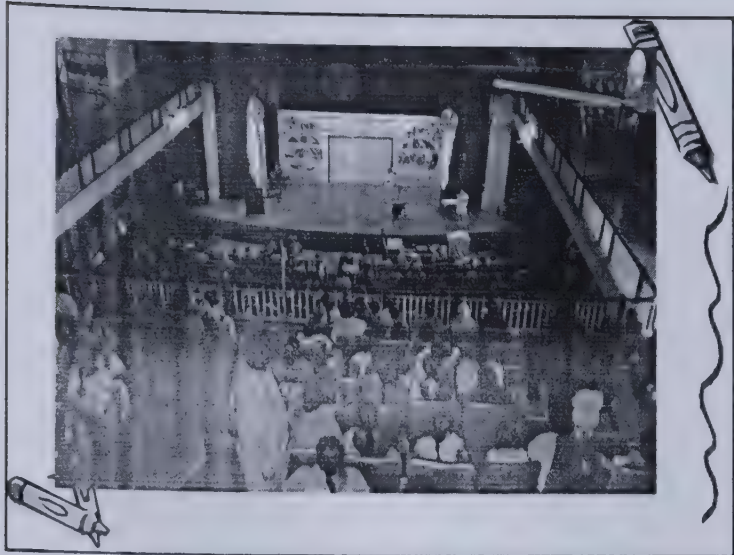
- Documentation/Research of the situation of Public Health
- Documenting the cases of people experiencing denial of health services
- Filing formal complaints with the Lokayukta and SHRC
- People Testifying on their experiences of public health - people with disability, Mental health, PLHAs, Women, Dalits
- People demanding health services

- 



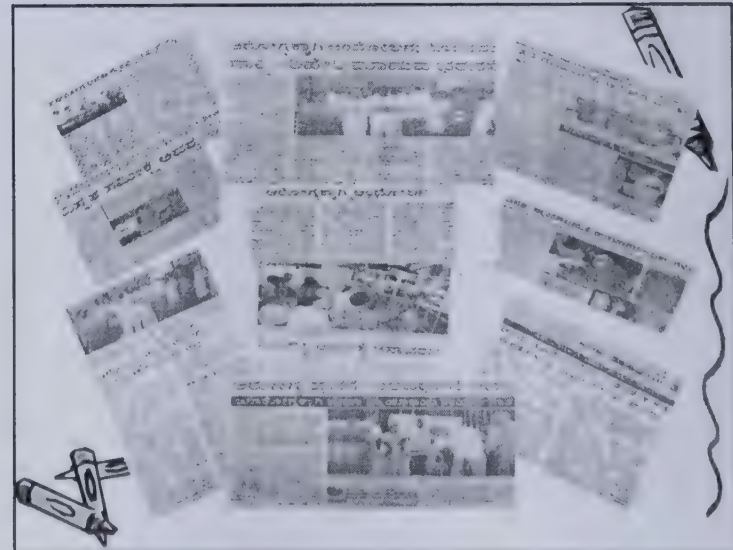
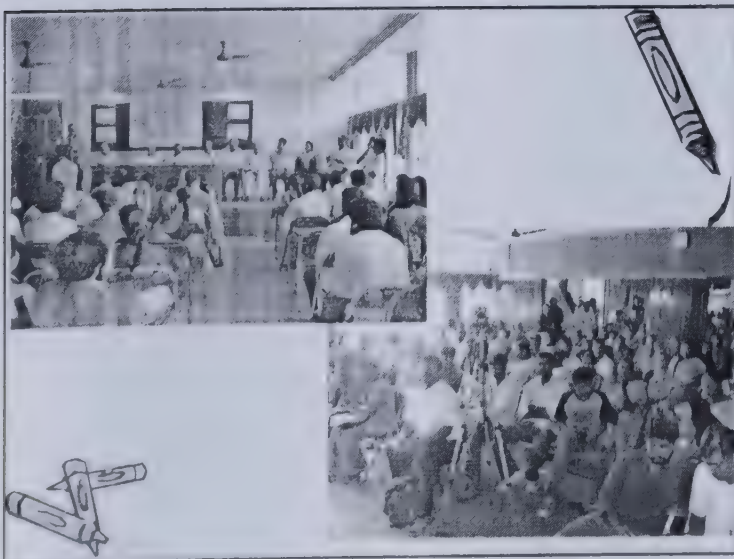






## District Public Hearing

- Planned in 8 districts
- Process:
  - Consultation and orientation
  - Training and Capacity Building
  - Fact finding and research on the PHCs
  - Collation of data and documentation
  - Recording Testimonies of people
  - Organising the Public Hearing
  - Follow up to improve the PHCs







## Creating space for dalit voices

- JAAK has taken an active initiative to partner with the most vulnerable among the dalits (pourakarmikas, manual scavengers, women agricultural laborers and child laborers) through organizations such as: Thamate, JMS, NJMO, Mahaadiga (a network of 34 CBOs and collectives)

## Integration of marginalized communities in RTHC since 2008

- Initiated a study on health status of pourakarmikas (sweepers, manual scavengers) in chitradurga district
- Conducted fact-finding on:
  - Atrocity and social boycott of dalit community in Raichur and Bagalkote districts
  - Manual scavenging in Savanur taluk, Haveri district and in KGF, Kolar district
  - Brutal attack and murder of a dalit woman in Tumkur district

## PANS Review (2010-11)

- Conducted in two parts.
- The 1<sup>st</sup> part was organized on 26<sup>th</sup> August, 2010 at Haveri:
  - 45 District Forum members representing 23 organisations from 10 districts
  - Representatives of the JAAK North Karnataka Forum
  - Core Committee members of JAAK participated

## PANS review... (Contd)

- The 2<sup>nd</sup> part was conducted at the state level meeting (15<sup>th</sup> -16<sup>th</sup> July 2011)
- 27 partner organizations participated along with representatives of the North Karnataka Forum and the state-level Core Committee

## Methodology

- A questionnaire was developed which each partner organization filled in separately
- This was followed by small group discussion in district-wise groups and focused on:
  - Skills and strengths gained by the activists in the process
  - Strategies that worked, did not work
  - New friends / associates found
  - Gains for JAAK and changes that have happened
  - Follow up done in districts
  - Tasks at hand for the future

This provided a feedback about JAAK's present strengths, weaknesses, opportunities and challenges

## JAAK: Strengths

- Identity as a health rights movement
  - Through various health actions, districts forums were now well-known
  - Health rights - no longer a separate stand-alone issue
  - Administration had to sit and respond to issues raised by JAAK
- Structure and composition of JAAK
  - All partners contribute in the spirit of volunteerism
  - Democratic model of functioning through participatory collective decision-making and team work
  - Diverse composition with varied perspectives and skills enriching the health rights landscape
  - Built solidarity with other movements and thereby mobilizing larger support for its work on health rights





## Strengths

- Documentation and publication:
  - Brochures, films and booklets on health rights issues
  - Quarterly Newsletter
  - Publications in Kannada had ensured grassroots activists' access to issues of health and human rights, political economy of health, globalization
- Capacity building
  - JAAK had enhanced activists' capacity to lead health actions independently
  - Developed a curriculum on HHR trainings
- Media intervention at district and state levels
  - Articles in local and state level newspapers
  - Increasing visibility of JAAK work in the media

## JAAK: Challenges

- Network dynamics and administration
  - All groups in JAAK do not work together with the same intensity
  - All groups do not necessarily endorse JAAK's ethos and perspective
  - Communication and coordination needs to be more efficient
- No sustained monetary support for activities
- Community presence needs to improve
- Evolving a more comprehensive strategy to deal with problems in the health system: Adequacy of rights approach?
- Need to strengthen links with other state PHMs and with JSA

## The Road ahead for JAAK

- *Strategic issues*
- Ensure centrality of community by starting at the grass root level.
- Connecting with other networks, movements at the state and district levels
- Involve PRI
- Train the various committees that are part of the hospital/health set up on health rights
- Redressal strategies to be strengthened: lobbying for Legal Compensations in cases of health denials
- Mobilizing Information through RTI

## The Road ahead...

- JAAK form, structure and capacity-building
  - Consolidate it at the state and at the zilla/taluk level
  - Representatives from district to be at the state core committee.
  - Have an organization that can take up the "office", structure at the district level.
  - Training in using technology to help in better communication, documentation/research
  - Immediate helpline for the health workers/activists of JAAK
  - Need fulltime activists for JAAK
  - Exposure visit/or learning for health Activists

## The Road ahead...

- Set up a media intervention unit for JAAK
- Thematic issues:
  - A comprehensive way to look at the social determinants of health - employment, food security, housing, water, education
  - Preventing privatization of health care and
  - Regulation of the private health care sector

Health For All at least  
NOW!!





# JAAK ACTIVITY LIST-2000-2011

Sl. No	Name / title of activity	Category	Place	Date(s)	Month	Year
	JAAK Kalajatha Song book released	Publications			July	2000
	State Level JAA-K convention meeting (Jannarogya Sabha) in Davangere	Comiitee meet	Davangere	26-11-2000	November	2000
	Janaarogya Sabhe (Health Assembly)	H.Assembly		27-11-2000	November	2000
	Jan Swastya Sabha- National Health Assembly	H.Assembly	Dakhia	18-11-2000	November	2000
	<u>PHD 1</u>			30-11-2000	November	2000
	JAAK published 5 articles on Kannada		Bangalore	01-12-2000	December	2000
	1. Jaagathikaranadinda Janarogyakkenadeethu? Janarogya sabhe puthshaka malike 1. published by Bharath Gyan Vigyan Samithi. Bangalore. P 1-54					
	2. Kri. Sha 2000da velege ellarigu arogya -- nirdharavenayithu. Janarogya sabhe puthshaka malike 2. published by Bharath Gyan Vigyan Samithi, Bangalore. P 1-68					
	3. Badukalu Yogyavada Badukigagi. Janarogya sabhe puthshaka malike 3. published by Bharath Gyan Vigyan Samithi, Bangalore. P 1-65					
	4. Namma Asthithwavu pramukhavaguva jagatthu. Janarogya sabhe puthshaka malike 4. published by Bharath Gyan Vigyan Samithi, Bangalore. P 1-66					
	5. Arogyapalayana vyaparikaranavannu edurisivudu. Janarogya sabhe puthshaka malike 5. published by Bharath Gyan Vigyan Samithi. Bangalore. P 1-95					
	State Janaarogya Andolana Launching programme in SCM House, Bangalore	Publications	Bangalore	07/04/01	April	2001
	Workshop on Ratikonal Drugs with DAF-K & JAAK	JAAK Launch	Bangalore			
	Essential Drug workshop in Bangalore with Karnataka Medical and Sales Representative (KMSRA) Association and CHC	Workshop	Bangalore	25-11-2002	November	2002
	Orientation for field level workers with CHAI-KA, CHC and JAAK in Mandya	Workshop	Bangalore	25-03-2002	March	2002
	discussion on Health of the urban poor in Bangalore	Training	Mandya	12/08/02	August	2002
	Workshop on Drugs and Peoples Health in Bangalore with DAF-K, CHC & JAAK	Discussions	Bangalore	07/11/02	November	2002
	Peoples Health Dialogue about Health -with MSK and another state committee members	Workshop	Bangalore	25-11-2002	November	2002
	Public Health District level dialogue in Bellary on 24th September 2002	Dialogue	Bangalore	23-24-09-2002	September	2002
	Drugs and Peoples health - JAAK, CHC and DFA-K	Dialogue	Bellary	24-09-2002	September	2002
	Campaign against bhopal gas tragedy	Training	Bangalore	04/09/02	September	2002
	Orientation to Health Workers 14-16th July 2002	Celebrations	Bangalore	02/07/02	July	2002
		Training		14-07-2002	July	2002

Karnataka (33)





	International Women's Day celebrations on 28th May 2002			Bijapur	28-05-2002	May	2002
	Public Health day celebrations in Raichur, Tumkur on 16th April 2002		Celebrations	Raichur Tumkur	16-04-2002	April	2002
	Releasing Peoples Health Charter (Janaarogya Sannadu) in Womens Health Convention		Publications	Bangalore	16-04-2002	April	2002
			Meeting	Bangalore	05th to 07- 03-2002	March	2002
	Programme on Use of Local Health Traditions in Belgaum, Gokak on 4th & 5th November 2003		Trainings	Belgaum	4th & 5th 11 2003	October	2003
	JSA-NCC meeting in Bangalore on 26th & 27th July 2003		Meetings	Bangalore	26-27-07- 2003	November	2003
	District Workshop AT Dharwad and Shimogga		Workshop	Dharwad Shimogga	17-03-2003	March	2003
	District Workshop in Raichur supported by Vimukti		Workshop	Raichur	28-29-03- 2003	March	2003
	Health Workshop at Asian Social Forum-ASF in Hyderabad			Hyderabad	02-07-02- 2003	Febbruary	2003
	Meeting of Bangalore Urban NGOs to take forward Right to Food campaign in Bangalore		Meetings	Bangalore	14-08-2003	August	2003
	JABU Meeting with RFC		Meetings	Bangalore	14-08-2003	August	2003
	WSF - Sharing of JSA activities in World Social Forum in Bangalore			Bangalore	09/08/03	August	2003
	WSF - Sharing of JSA activities in World Social Forum in Bangalore				15-08-2003	August	2003
	WSF - Sharing of JSA activities in World Social Forum in Bangalore				21-08-2003	August	2003
	JAAK State Coordination Committee meeting in Bangalore on 12th December 2003		Committee meet	Bangalore	12/12/03	December	2003
	JAAK convers reconstituon meeting in Bangalore		Committee meet	Bangalore	23-12-2003	December	2003
	JAAK State Committee meeting in Bangalore on 12th December 2003		Committee meet	Bangalore	12/12/2003	December	2003
	JAAK co chairperson shared about PHM to the postgraduate students of social work fromn sacred		Committee meet	Tirupattur,	03/12/03	December	2003
	Dialogue on Combating Corruption and the initaives of the Peoples Health Movement & An updt on The Global Peoples Health Movement and its initiatives during the Alma Ata 25th Anniversary on 22nd December 2003		Dialogue	Bangalore	22-12-2003	December	2003
	Dialogur on Epidemic of Corruption in Health services by Dr.H.Sudharshan and The Global Peoples Health Movement by Dr.Ravi Narayan in Bangalore on 22nd December 2003		Dialogue	Bangalore	22-12-2003	December	2003
	Orientation on Herbal Gardens for Primary Health Care- with FRLHT, hosted by BALF organisation for Rural Development, Tiptur		Trainings	Bangalore	22-23-12- 2003	December	2003





	JAAK sharing about People's Health Charter to the groups of women self help groups				15th November 2003	November	2003
	Programme on Use of Local Health Traditions in Primary Health Care in Bangalore			Discussions	Bangalore		
	Meeting with FEVORD-K			Trainings	Bangalore	4th & 5th 11 2003	2003
	Programme on Use of Local Health Traditions in Primary Health Care in Bangalore			Meetings	Bangalore	23-09-2003	2003
				Training	Bangalore	11-12-09-2003	2003
	Womens Issue in Peoples Health Charter in Bangalore			Training	Bangalore	19-09-2003	2003
	JAAK representatives participation in National Law school of India University (NLSIU) Bangalore-Workshop on Literacy and Health			Workshop	Bangalore	08/09/03	2003
	Addressing NSS Officers and Faculty of Sociology and Social Work Department in Gulbarga university				Gulbarga	26-09-2003	2003
	JSA Working Group Meet in ISI, Bangalore on 26th & 27th July 2003			Comiitee meet	Bangalore	26-07-2003 27-07-2003	2003
	The National Coordination Committee meeting of JSA in Bangalore on 26th & 27th July 2003			Comiitee meet	Bangalore	26th & 27-07-2003	2003
	State Coordination Committee meeting in Bangalore			Meetings	Bangalore	15-07-2003	2003
	JABU Meeting with RFC			Meetings	Bangalore	31-07-2003	2003
	Meeting of Bangalore Urban NGOs to take forward Right to Food campaign in Bangalore				Bangalore	31-7-2003	2003
	Promotion of Peoples Health Movement (World Sick Day) in Bangalore with CHA-IK			Celebrations	Bangalore	08/02/03	2003
	JAAK District workshop in Hassan and Tumkur Dist with Azad Rural Dev. Society and Hoysala			Workshop	Hassan	15-16-02-	2003
	Bangalore Rural District Workshop in Nelamangala, Bangalore Rural with Sandeep Seva Nilaya			Workshop	Nelamangal	20-02-2003	2003
	Asian Social Forum in Hyderabad 2-7th January 2003				Hyderabad	02to 07-01-2003	2003
	Sessio on Corruption on Health Services and importance of people's movements- by Sudarshan with			Participation	Bangalore	20-10-2003	2003
	JAAK State Coordination Committee meeting in Bangalore on 5th October 2004			Committee meet	Bangalore	05/10/04	2004
	Orientation cum planning meeting at Doddaballapur for the Bangalore rural district public hearing.			Trainings	Doddaballa pur	07/10/04	2004
	The southern Regional Public Hearing on Denials of Right to Health Care in Chennai 29th August			Dialogue	Chennai	29-08-2004	2004
	NHRC Public Hearing in Chennai 29th August 2004			Dialogue	Chennai	29-08-2004	2004
	Public Health System- Dialogue in Bangalore on 28th September 2005			Dialogue	Bangalore	28-09-2005	2005
	Workshop on " Exploring the possibility of linkages with JAA-K for Alliance Building			Workshop	Bangalore	23-09-2005	2005





	Core group meeting in Bangalore 25-09-2005		Committee meet	Bangalore	25-09-2005	July	2005
	State Health Assembly-II in Bangalore 11-07-2005		H.Assembly	Bangalore	11/07/05	July	2005
	11nd peoples Health Assembly 7th July 2005			Bangalore	07/07/05	July	2005
			H.Assembly				
	State Health Assembly in Bangalore 01-06-2005		H.Assembly	Bangalore	01/06/05	June	2005
	Meeting with PHM international Steering group members in Bangalore 13-04-2005		Meetings	Bangalore	13-04-2005	April	2005
	Dharana on account of World Health Day in Bangalore 27-04-2005		Participation	Bangalore	27/4/2005	April	2005
	JAAK Newsletter Vol.II released		Publications/Art	Bangalore	04/01/05	April	2005
	Planning meeting for the People's Health Day 23-03-2005 in Bangalore		Meetings	Bangalore	23-03-2005	March	2005
	JAAK Newsletter Vol.1 released		Publications/Art	Bangalore	02/01/05	February	2005
	JAAK Core group meeting in Bangalore 17-10-2006		Committee meet	Bangalore	17-10-2006	October	2006
	Consultation meeting on 1. World Bank Project in Karnataka and Primary Health Care in Karnataka in CHC, Bangalore		Meetings	Bangalore	06/10/06	October	2006
	Joint conveners meeting of JAAK to strengthen Primary Health Care Campaign		Committee meet	Bangalore	10/11/06	November	2006
	State Level HHR Training in Tumkur on 16th & 17th December 2006		Trainings	Tumkur	16-12-2006 17-12-2006	December	2006
	Kolar district meeting 16-11-2006		Meetings	Kolar	16-11-2006	November	2006
	"Why Right to Health Care" Policy brief release and distribution			Bangalore		September	2006
			Publications				
	"Muktha Samajawadi Mathukathe" Article about JAAK		Publications	Bangalore		September	2006
	Chamarajanagar Dist Meeting 19-07-2006			Chamarajanagar	19-07-2006	July	2006
			Committee meet	agar			
	Consultation on 'Health of the Urban Poor' in Bangalore city 27 July 2006		Meetings	Bangalore	27-07-2006	July	2006
	Right to Primary Health Care Planning Meeting		Meetings	Bangalore	25-07-2006	July	2006
	Chamarajanagar district meeting of the Right to Health Care Campaign will be held on 19th July 2006			Chamarajanagar	19-07-2006	July	2006
			Meetings	agar			
	Kolar district action will be held on 20th July 2006 in Kolar		Meetings	Kolar	20-07-2006	July	2006
	Tumkur district meeting of the Right to Heartily Care Campaign will be held on 18th July 2006		Meetings	Tumkur	18-07-2006	July	2006
	State Level JAAK Meeting in Bangalore on 27-06-2006		Committee meet	Bangalore	27-06-2006	June	2006
	Peoples Partnership for Primary Health care in view of World Health Day		Celebrations	Bangalore	06/04/06	April	2006
	On account of "World Health Day" celebrations launching PPP care in Bangalore		Celebrations	Bangalore	06/04/06	April	2006
	Meeting on Revitalization of Public Health System in Bangalore			Bangalore	25-04-2006	April	2006
			Meetings				
	Core group meeting to discuss NHRC recommendations 01-03-2006		Committee meet	Bangalore	01/03/06	March	2006
	Orientation to Women of Mahila Okkuta in Kolar on 23-03-2006		Trainings	Kolar	23-03-2006	March	2006





	Health Action Day in all JAAK districts on same day 29th October 2007	Celebrations	All Districts	29-10-2007	October	2007
	HUMAN CHAIN - (Public Action) demanding Right to Health on Oct 29, 2007 in Bangalore, Town Hall	Dialogue	Bangalore	29-10-2007	October	2007
	Preparatory meeting for October 27, Health Action day for Raichur, Gadag, Haveri, Dharwad,	Meetings	Davangere	05/10/07	October	2007
	South Karnataka State Level Planning Meeting 08-10-2007	Meetings		08/10/07	October	2007
	Follow up meet of October 29, 2007 Health Action Day 12&13th November 2007	Meetings	Bangalore	12-13-11-2007	November	2007
	Belgaum District Meeting in Belgaum on 17-12-2007	Meetings	Belgaum	17-12-2007	December	2007
	State Committee Meeting in Sangama Office, Bangalore on 20-08-2007	Committee meet	Bangalore	20-08-2007	August	2007
	Bangalore Urban meeting in Samvada, Bangalore	Meetings	Bangalore	25-08-2007	August	2007
	Doddaballapur District Meeting in Doddaballapur	Meetings	Doddaballapur	25-08-2007	August	2007
	JAAK District meeting in Maddur 14-08-2007	Meetings	Maddur	14-08-2007	August	2007
	Review of 29th October and State Committee meeting in Bangalore 12th & 13th November 2007	Meetings	Bangalore	12-11-2007 13-11-2007	November	2007
	Chitradurga dist meeting 27-09-2007	Meetings	Chitradurga	27-09-2007	September	2007
	JAAK State Level Meeting	Committee meet	Bangalore	20-07-2007	July	2007
	JAAK Health resource group meeting	Committee meet	Bangalore	10/05/07	May	2007
	Meeting on Revitalisation of PHC Campaign on 20th April, 2007 in Bangalore	Campaign	Bangalore	20-04-2007	April	2007
	JAAK state Committee meeting in Bangalore 20-04- 2007	Committee meet	Bangalore	20-04-2007	April	2007
	NHA2 Followup and Planning meeting on 20th April 2007 in Bangalore	NHA	Bangalore	20-04-2007	April	2007
	JAAK Core Committee Meeting in Bangalore 07-03-2007	Committee meet	Bangalore	07/03/07	March	2007
	NHA 2 23rd - 25th March, 2007 at Bhopal	NHA	Bhopal	23-25-03-2007	March	2007
	JAAK Dist meeting in Chamarajanagar on 01-02-2007	Meetings	Chamarajanagar	01/02/07	February	2007
	National People's Health Assembly II February 2007.	NHA	Bangalore	02/01/07	February	2007
	NRHM awareness programme in BIRDS college. Belgaum on 18-10-2008.	Trainings	Belgaum	18-10-2008	October	2008
	District Capacity Building programmes held at Belgaum on 19-10-2008	Trainings	Belgaum	19-10-2008	October	2008
	JAA-K Newsletter.	Newsletter	Bangalore	25-12-2008	December	2008
	Health as a Human Right Training	Trainings		19th to 21st 08-2008	August	2008
	Core Committee meeting held on 12-09-2008 in Bangalore	Committee meet		12/09/08	September	2008





	PROTEST DEMANDING SPEEDY JUSTICE TO A.T.BABU in Bangalore	Solidarity	Bangalore	11/09/08	September	2008
	Community Health Workers training in Bangalore 10th and 11th September 2008.	Trainings	Bangalore	10th & 11th Sep 2008	September	2008
			Bangalore	21-07-2008	July	2008
	State Committee Meeting in Bangalore 21st July 2008.	Committee meet				
	Dharna and condolence meeting is being organised on 24th July 2008 at Bangalore.	Solidarity	Bangalore	24-07-2008	July	2008
	CANDLE-LIGHT VIGIL in Solidarity with the Bhopal Gas Survivors who are on an indefinite	Solidarity	Bangalore	21-06-2008	June	2008
	CANDLE LIGHT VIGIL IN SOLIDARITY WITH HUMAN RIGHTS DEFENDERS- Release Dr. Binayak Sen	Solidarity	Bangalore	14-05-2008	May	2008
	capacity building workshop in Davangere	Trainings	Davangere	12th & 13-03-2008	March	2008
	capacity building workshop in Mysore	Trainings	Mysore	22rd 23rd - 03-2008	March	2008
	capacity building workshop in Tumkur	Trainings	Mysore	27th 28th - 03-2008	March	2008
	capacity building workshop in Shimogga	Trainings	Shimogga	10th & 11-03-2008	March	2008
	Article in Kannada regarding the Novartis Boycott by Dr. Gopal Dabade	Article	Dharwad	15-02-2008	February	2008
	JAAK Core Committee Meeting at CMAI, Bangalore on 01-02-2008	Committee meet	Bangalore	01/02/08	February	2008
	HHR training programme in Chamarajanagar on 19th - 20th February 2008	Trainings	Chamarajan	19-02-2008	February	2008
	Kannada Training Programme on "Health as a Human Right" in Bangalore.	Trainings			February	2008
	District Meeting in Davangere on 31-01-2008	Meetings	Davangere	31-01-2008	January	2008
	letter has been prepared as JAAK response to the flood situation in north Karnataka and is aimed to be sent to the to the various districts and State Administrative Authorities urging them to recognise Public Health crisis following the floods in Northern Karnataka	Advocacy	Bangalore	08/10/09	October	2009
	11th October North Karnataka JAAK meet in Dharwad	Meetings	Dharwad	11/10/09	October	2009
	JAAK Handout regarding flood effect- PHM response to the floods in north Karnataka.	Newsletter	Bangalore	05/10/09	October	2009
	series of 8 district public hearings on primary health care have been organised as part of the ongoing 'Right to Primary Health Care Campaign'. the first public hearing was held at Davangere.		Davangere	23-12-2009	December	2009
	Davangere district on 23rd December 2009.	Dialogue				
	JAA-K district level meetings in the context of organizing Public Hearing and Strengthening Dist Committees. 21st November 09 - Bagalkote	Meetings	Bagalkote	21-11-2009	November	2009
	JAA-K district level meetings in the context of organizing Public Hearing and Strengthening Dist Committees. 20th November 09 - Bellary	Meetings	Bellary	20-11-2009	November	2009





	JAA-K district level meetings in the context of organizing Public Hearing and Strengthening Dist Committees. On 19th November 09 - Davangere, 20th November 09 - Bellary and 21st November 09 - Bagalkote	Meetings	Davangere	19-11-2009	November	2009
	HHIR Training in Haveri District on 29th & 30th November 2009	Trainings	Haveri	29th & 30th 11-2009	November	2009
	Two children norms statement by JAAK on 21st September 2009	Article	Bangalore	21-09-2009	September	2009
	discussion on urban health scenario in Bangalore	Discussions	Bangalore		September	2009
	State Committee Meeting in Bangalore 20th & 21st June 2009	Committee meet	Bangalore	20th & 21st June	June	2009
	Fact Finding on Social bycot on Dalit community, at Tadakal, villege. near Potnal, Manvi thaluk,	Advocacy	Tadkal	01/04/09	April	2009
	Core committee meeting about the Jansamvad	Committee meet		05/03/09	March	2009
	State level Public Hearing 31st March 2009 in Bangalore	Dialogue	Bangalore	31-03-2009	March	2009
	Pre plan meeting with Bangalore Based organasations on 11th at Bangalore, Jansahayog office	Meetings	Bangalore	11/3/2009	March	2009
	State Committee meeting on 16th Februrary 2009 at regarding State level rally and public hearing	Committee meet	Bangalore	16-02-2009	February	2009
	Core Committee Meeting held on 2-01-2009 at CHC, Bangalore.	Committee meet	Bangalore	01/01/09	January	2009
	Attended case hearings (complaint lodged to Lokayukta about the disposal of drugs). In hearing	Advocacy	Haveri	6/10/2010	October	2010
	Inspection committee (Lokayukta office) came to inspect Drugs that were thrown out (Kari lodged complaint about the drugs) Notice issued to the concerned officials.	Advocacy	Haveri	20-10-2010	October	2010
	Complaint lodged in the name of Manjunath about the Malaria and Rat Fever found in GADIGANUR villages and death of 23 people.	Advocacy	Hospet	25-20-2010	October	2010
	Davangere Dist committee meeting conducted with 4 JAAK representatives. Shared about other district follow ups. Next visited Ucchangi Durga PHC and got the details. Sent letters to DHO, DC and THO under letter campaigns.	Meetings	Davangere	7/10/2010	October	2010
	Follow up of Public Hearing by Karibasabba in Haveri .	Meetings	Haveri	1/10/2010	October	2010
	13-10-2010 Notice issued to DHO from SHRC and called for hearing	Meetings	Haveri	18-10-2010	October	2010
	meeting in Haveri district of Havanur. Shared about JAAK. Letter campaign conducted.	Trainings	Chitradurga	12 10/2010	October	2010
	Conducted 1 day HHR training in "MALAKALMUR" chitradurga dist. BSW students and CHLP fellows were participated.		Haveri	2 10 2010	October	2010
	Survey done in Haveri 2 subcenter in Byadagi Taluk, 3 subcenters photos were taken. Discussed with the Staff about the services to be given , problems faced, public coporation and reserve funds				October	2010





	Case study about the 3 death cases in Jagalur taluk CB Gollarhatti about 3 death cases	Advocacy	CB Gollarahatti of Davangere	4/11/2010	November	2010
	Prepared Manual coverin the issues of Health Denial, Child Death,Dengue cases and other problems in Haveri Dist - sent these reports to GP President, Justice , Lokayukta and SHRC etc	Advocacy	Haveri	8/11/2010	November	2010
	Case study about the 3 death cases in Devi Hosur, Haveri - Death cases due to Dengue cases	Advocacy	Haveri	10/11/2010	November	2010
	Conducted 1 day workshop in Kekkeri of Khanapur Taluk of Belgaum dist to SHG womens	Workshop	Kekkeri of Belgaum	2/11/2010	November	2010
	13th March 2010 organised Haveri District public hearing, we conducted 15 PHC, 1 Taliuka hospital, 1 community health center, And more then 15 Individual testimonies specially maternal Denials from Institutional delivery's , Negligence's and referring to privet hospitals, Discrimination's, snake bite,	Dialogue	Haveri	13-03-2010	March	2010
	Karibasappa visited Haveri DPMO about Snake bite that happens in district	Advocacy	Haveri	6-Apr-10	June	2010
	Raichur district Public Hearing preparatory meeting and Consolidation	Dialogue	Raichur	26-06-2010-27-06-2010	June	2010
	Raichur Public Hearing	Dialogue	Raichur	28-06-2010	June	2010
	Meeting with NJMO- with ASHA and plan about JAAK next months	Meetings	Raichur	30-06-2010	June	2010
	JAAK District Committee Meeting	Meetings	Davangere	12/12/2010	December	2010
	Meeting with the Haveri SHG members and visit to CHC, PHC of Haveri dist	Meetings	Haveri	8/12/2010	December	2010
	Chitradurga Dist Committee Meeting and HHR Training	Trainings	Chitradurga	& 14-12-2010	December	2010
	Followup of Public Hearings in Haveri by Karibsappa- Snake Bite, Matenal delth and Child death- 5 case studies	Meetings	Haveri	24-08-2010	August	2010
	Health as aHuman Right" Training prog in Haveri - Krushi Abhivruddi Kendra-Haveri	Trainings	Haveri	26-27-28-08-	August	2010
	JAA-K newsletter Vol.7 Published & printed	Newsletter	Bangalore	01/08/10	August	2010
	Bhangi issue- Savanur fact findding on 29th July, 2010.	Advocacy	Savanur	29-07-2010	July	2010
	Chitradurge Protest	Dialogue	Chitradurga	30-07-2010	July	2010
	Tumkur Public Hearing	Dialogue	Tumkur	21-07-2010	July	2010
	Preparatory works for Tumkur public hearing	Dialogue	Tumkur	18-21st July	July	2010





	Preparatory works meeting for Chitradurga Protest/pub hearing	Meetings	Chitradurga	26th & 30-	July	2010
	Follow up meeting -Haveri Public Hearing	Meetings	Haveri	7-Nov	July	2010
	Meeting in Haveri "CIRCUIT HOUSE " from "SAGE". Decided to conduct rally about Raitha Sangha		Haveri	7-Oct		
	Decided to conduct State level Public Hearing in Dharwad	Meetings			July	2010
	The public action on health of Chitradurga district organised on 30th July, 2010 at Chitradurga		Chitradurga	30-07-2010	July	2010
	Health Denial study and record - Farmer death by Snake bite in Mallur village	Advocacy	Haveri	30-05-2010	May	2010
	Meeting in CHC about the JAAK reprots and documentation	Meetings	Bangalore	5-Oct-10	May	2010
	Folow up Meeting of HAVERI Public Hearing - Byadagi, Chikkabasur PHC Dr.Urankar	Meetings	Haveri	25-05-2010	May	2010
	Follow up meeting of HAVERI Public Hearing - with THO	Meetings	Ranebennur	7/5/2010	May	2010
	JAA-K prepared Election Manifestos to the contestants and the public for Gram Panchayath elections is going to held on 8th and 12th of May, 2010 in Karnataka.	Advocacy	Bangalore	23-04-2010	April	2010
	On Account of World Health Day JAA-K organised Press Meet in Bangalore Press Club on 06-04-2010 for demanding the Karnataka Public Health Services Guarantee Act and National Health Act	Celebrations	Bangalore	06/04/10	April	2010
	state level meeting with the core group held on 25.04.2010 at CYCD Bangalore. In Continuation with this meeting on 26.04.2010 with some core committe members again the meeting held for	Meetings	Bangalore	25-04-2010 &	April	2010
	Belgaum Public Hearing		Belgaum	19-03-2010	March	2010
	Bellary Public Hearing	Dialogue	Bellary	27-03-2010	March	2010
	SA National Coordination Committee - national meeting that on 20-21 Feb 2010 in Calcutta	Committee meet	Calcutta	20-21-02-2010	February	2010
	Bagalkote public Hearing is organised on 19th feb2010, at Dr. B.R.Ambedkar Bhavan, Balked,	Dialogue	Bagalkote	19-06-2010	February	2010
	HHR trg to be held in Belgaum on 31-01-10	Trainings	Belgaum	31-01-2010	January	2010
	JAAK-KHPT-CBPS meeting and inputs 11th March 2011	Comittee meet	Bangalore	11-03/11	March	2011
	Participation in Seminar on Public Spending and its Effectiveness: Selected Studies from Karnataka" (Health: Education: Water: Local Self-Government)	Discussions	Bangalore	25-06-2011	June	2011
	Discussion on Politics of Health 18-19th June in Hubli	Discussions	Hubli	8-19-06-2011	June	2011
	Janarogya Andolana Karnataka RPHC (Right to Prepare Health Care) sub-group meeting	Comittee meet	Bangalore	30-08-2011	August	2011
	JABU Convening team meet - C-far, Bangalore	Meetings	Bangalore	18-08-2011	August	2011
	JABU team meet CHC Bangalore	Meetings	Bangalore	19-08-2011	August	2011





	JAAK North Karnataka Forum core group Meeting	Meetings	Haveri	28-08-2011	August	2011
	Health as a Human Rights Training	Trainings	Bangalore	1 to 3-08-	August	2011
	State meeting of JAAK is 15-16 July 2011 in Bangalore	Comittee meet	Bangalore	5-16-07-2011	July	2011
	District Health and Human Rights -Raichur	Trainings	Raichur	- 17-07- 2011	June	2011
	Meeting to strengthen the JAA-K in Chikkaballapura district.	Meetings	Chikkaballapur	11/05/11	May	2011
	State Core/Working Group Meeting 29.04.2011	Comittee meet	Bangalore	29-04-2011	April	2011
	State Core/Working Group Meeting in Bangalore on 29.04.2011	Comittee meet	Bangalore	29-04-2011	April	2011
	Raichur Dist committee meeting on 22-04-2011	Meetings	Belgaum	22-04-2011	April	2011
	Raichur Dist committee meeting on 23-04-2011	Meetings	Raichur	23-04-2011	April	2011
	Davangere-District Committee Stregthnening meeting	Meetings	CHC	19-03-2011	March	2011
	JAAK Newsleter Vol.8 Published and Printed	Newsletter	Bangalore	01/03/11	March	2011
	JAAK Printed 1. Health Policy Brief 2. PHM-Kannada Pamphlet 3. PHM English Pamphlet 4. RPHC Handout	Publications	Bangalore	01/03/11	March	2011
	JAAK Core committee meeting	Comittee meet	CHC	22-02-2011	February	2011
	Chitradurga dist -Follow up meeting	Meetings	Chitradurga	19-02-2011	February	2011
	North Karnataka Forum Meeting	Meetings	Haveri	11/02/11	February	2011
	HHR Training to GP members	Trainings	Davangere	20-02-2011	February	2011
	HHR Training in Tumkur	Trainings	Tumkur	4-25-02-2011	February	2011
	North Karnataka Forum Meeting at Haveri on 11th Feb 2011		Haveri	11/02/11	February	2011
	Team Sharing with Karibasappa and Obalesh	Meetings	Bangalore	18-01-2011	January	2011
	JAAK Davangere Dist committee sterengthening meeting	Meetings	Davangere	21-01-2011	January	2011
	NHRF Team Visit		Bangalore	19-01-2011	January	2011
	On behalf of International Women's day Celebrtions in Bijapur with Janodaya and CHC-" Promoting Wome's Collective for Community Health Management.	Celebrations				





### Minutes of MNI meeting

Date : 24<sup>th</sup> October'2011

Venue: Catholic Health Association of Tamilnadu (CHAT) office – Tiruchy

#### Members attended:

1. Mr. Arokiyam Puspharaj – Voluntary Health Association of Kanniyakumari (VIAK)
2. Dr. Kulanthaivel Pandiyan – Tamil Nadu Science Forum (TNSF) and Convenor of MNI.
3. Mr. Martin - Federation of Consumer Organizations of Tamilnadu (FEDCOT)
4. Mr. Francis – Catholic Health Association of Tamilnadu (CHAT)
5. Mr. Shankar – Dharmapuri Voluntary Associations Network Initiative (DHVANI)
6. Dr. Chandra – D Arul Selvi – Community Based Rehabilitation (DAS - CBR) & Tamilnadu Health Development Forum (TNHDF)
7. Dr. Shanmuga Velayudham - TN-FORCES
8. Ms. Saulina Arnold – Tamilnadu Voluntary Health Association (TNVHA)
9. Mr. Ameerkhan – Community Health Cell Extension Unit, Society for Community Health Awareness Research and Action (CEU – SOCHARA) & Co-convenor MNI.
10. Dr. Rakhal - Community Health Cell Extension Unit, Society for Community Health Awareness Research and Action (CEU – SOCHARA) ~~Permanant~~Permanent invitee on behalf of National Coordination Committee of JSA
11. ~~Prof.~~ Prof. Rajamanickam – ~~Tamil~~ Tamil-Nadu Science Forum (TNSF).- Special invitee
12. Mr. Venkatesan – Center for Public Health and Equity, Society for Community Health Awareness Research and Action (CPHE - SOCHARA)-) - Special invitee

#### Members who did not attend:

Mr. Dhandapani from Adiyaalam could not attend the meeting.

#### Agenda

The MNI steering committee meeting was held on 24<sup>th</sup> October'2011 in CHAT office and the following agenda was discussed.

1. MNI activities in the last decade focusing on the last three years – sharing by members.
2. MNI – PANS process. Discussing process so far and what more needs to be done.
3. MNI participation in the Nagpur extended JSA NCC meeting.
4. Future activities of MNI
  - Issue of Pentavalent vaccine – evolving an MNI stand.
  - Peoples struggle against Nuclear plant in Koodankulam – evolving an MNI stand.
5. ~~Health in 12<sup>th</sup> five year plan~~  
Sharing of Right to food campaign activities

### The discussion of various activities of MNI

As part of the a first agenda point members started sharing of their activities of MNI their own organisation's network was involved in over the last 10 years, involvement in MNI activities. Ameer Khan summarized the activities of MNI and other members contributed and added to the list (annexure -I).

### The PANS process discussion

For the PANS process it was decided that (1). The draft questionnaire which was initially circulated to the SC members will be modified to include a few activities / campaigns that were missed (2). The modified questionnaire will be circulated to all the members networks who were ever are all involved in the MNI activities since 2000 (The secretariat and the steering committee members will circulate to the member organisation and final filled copy will be sent to secretariat for compilation) (3). The deadline for receiving the filled response from the members is 24<sup>th</sup> November 2011. (4) It was decided that after returning from the Nagpur meeting, MNI will have a larger meeting inviting all the members (including active as well as not presently active) in December first week.

As a part of discussion on organizational strengthening PANS process members identified the following issues:

- There was very little communication reaching the individual networks regarding the activities of JSA at the national level. It was pointed out that many of the stands taken or discussions occurring at the JSA national level were not reaching the different networks in the state MNI.
- There was also not regular communication within the state itself. Thus while some activities are common and a few networks are involved, information of various campaigns need to be regularly communicated to all members. Only then will there be a feeling of belonging to the network.
- There was a feeling that there were not enough regular meetings of either the steering committee or the general body / council (which includes all the network members).
- It was pointed out that many decisions regarding organizational issues which were taken at a meeting in 2009 are yet to be implemented.
- There seemed to be a leadership deficit in the network.
- It was pointed out that all the network members were doing MNI work on a voluntary basis. Similarly all the network members are NGOs / academics etc. who are extremely busy. Thus while there is a lot of contribution at times that there is a particular call for a campaign, there does not seem to be any ongoing activity / discussion.
- Similarly each of the member networks have different strengths, these strengths need to be taken into account while planning for and envisaging future activities of MNI.
- It was also felt that we were limiting all our discussions to the present steering committee, it was felt that we need to build up processes to bring in newer ideas etc.



Based on the above set of issues identified the members then proceeded to discuss some possible suggestions that will contribute to strengthening the network. The following were some of the suggestions made:

suggested the following options that to strengthen the network

1. ~~1.~~ It was decided that ~~t~~The steering committee should meet more frequently. It was decided that on a regular basis the SC should meet at least three times a year.
- ~~1.2.~~ It was further decided that out of these three times at least once this meeting should be clubbed with a general council meeting (where all the member networks are invited).
3. ~~2.~~ It was decided that as discussed earlier "Regional Conveners" have to be established. As part of this the Regional Conveners (who will automatically be members of the SC will contribute by (1) Activating the MNI in the region; (2) Bring in geographically emerging issues to the steering committee for discussion and possible action / campaigns; (3) Also bring in issues of professional interest / area of expertise for discussion to the SC.
4. In this new scenario the SC will comprise of a group of regional convenors who will represent both geographical as well as expertise / area of interest based in the SC. The SC based on various resources available at that time will decide collectively on how to take the issue / s forward.
5. It was also suggested that the present structure of a Convenor, Co-convenor and secretariat needs to be revamped to bring in collective leadership and reduce burden on any single group. The SC will be the default implementing body. The general council will empower this group.
6. Note also needs to be taken of what the direction of other states and the national level are taking with regards to these issues and these can be discussed in detail post - Nagpur. — the present structure needs to be changed — synchronizing with national structure and to reduce the burden on individuals.
7. It was pointed out that network has to expand. It was suggested that each member needs to identify potential members for the network / area of work they are involved in.
8. The network should be inclusive and should invite new networks such as those involving/working on/with agriculture issues, agricultural labor, Dalits, womens issues and other networks.
9. Once there are more active members for some time we need to actively plan on expanding the present SC.
10. It was discussed that in general activities of the MNI needs to divided into two folds, one is to intervene / involve in the policy level issues including issuing press release, statements etc., another one is identifying one or two common issues / activities in which all the member organisations / member networks will involve and contribute at a larger mobilizational level.
- ~~2.~~ As these activities take of, it was also suggested that issue based circles be tried out to take forward specific issues.
- ~~3.11.~~ 3. Activities of the MNI needs to divided into two folds, one is to intervene / involve in the policy level issues including issuing press release, statements etc., another one is identifying one or two common issues / activities in which all the member organisation / members will involve and contribute

regular  
meeting

Regional  
(or)  
Zonal

collective  
leadership

group  
expansion



4. The network has to expand — Each member need to identify potential members for the network. The network should be inclusive and should invite new networks such as agriculture, health and other networks.

5. The steering committee can also be expanded in a phased manner — based on the organisation's contribution to MNI activities, ideology etc.

6. Issue based circle can be formed to address many issues as much as possible.

During the discussion of strengthening the network members raised the issue of being clear about the larger goal of MNI which is "Health for all — Now". It was also mentioned in the meeting that the organisations are rendering their support effectively whenever the invitation being issued so few activities had happened during the past though it was not in consistent basis. It was also mentioned in the meeting that the need of the hour is to strengthen the MNI institutionally and at the same time we need to honestly ask ourselves and find out from those who are not actively participating any more of "why the members are not participating / taking part / not responding to invitations adequately or consistently?"

The committee decided to take discuss and finalize these — up the issues of expansion and modification of structure in the next MNI meeting which is envisaged as a steering committee meeting + general council meeting following the Nagpur meeting and the following decisions were also taken.

Some specific decisions that the Steering Committee did make in this regard are as follows:

1. The steering committee will convene minimum of thrice in a year (with the frequency of every fourth month)
2. Every year larger level convention will be held
3. The next steering committee meeting will be held on 4<sup>th</sup> december'2011 in Chennai

The committee had discussion on the extended National Coordination Committee (NCC) meeting scheduled from 10<sup>th</sup> to 12<sup>th</sup> November'11 in Nagpur. The steering had put forward two suggestions to NCC:

1. One is to have regional level JSA meetings. This will ensure better communication at least between nearby states. It will also reduce the distance needed to travel for a JSA meeting. It was pointed out that most meetings of the NCC are held in the North and this was very difficult for network members / SC members to attend. Regional meetings would be logistically easier and probably ensure greater participation. Regular regional meetings could also reduce the need for frequent national level meetings.

2. It was also felt that there should be and two is a regular national level programs should be undertaken taken by the JSA. This will increase a feeling of belonging as well as increase the awareness of the members regarding national level issues. Similarly it was also mentioned that there should be a mechanism for the state units to suggest ideas for campaigns etc. so that campaigns etc. initiated will be relevant to the states / adapted to the states unique context.

National level

Regular Regional meetings

Regular National level programs



1-3. There needs to be a mechanism whereby the JSA stand on many major national issues be evolved and circulated to the state units and further to the different state networks. This needs to be done not only to increase JSA strength but also as a way of increasing awareness of various networks to national level issues and analyses.

Need for mechanism to circulate JSA stand.

Mr. Francis from CHAT, Mr. Shankar from GANG, Dr. Cehandra from TNHDF, one representative from TNSF, Mr. Pushparaj from VHAK and Mr. Ameerkhan from SOCHARA had expressed their willingness to attend the JSA-NCC meeting at Nagpur.

### Future Campaigns

The committee had lengthy discussion on the issue of the introduction of Pentavalent vaccine into the routine immunization program of the government. This is being piloted in Tamilnadu and Kerala issue. Ameerkhan initiated discussion by providing overview on the larger corporate interest to introduce the vaccine into India's UIP, the possible impact on the public health system by vaccine, impact on health budget and ongoing arguments on the efficacy and the safety of vaccine from the example of Srilanka's, Bhutan and Pakistan's experience. Rakhal added by saying that we need to make out counter arguments could be multidimensional including a range of issues including (and not exclusively) on the basis of epidemiology, protective efficacy, side effects, impact on the public health system, opening up to / bowing down to corporate pressure etc. etc. the past experience of pentavalent introduction in neighbouring countries and the local context of Tamilnadu. We also need to take into account the specific context of Tamilnadu.

The committee had discussion on the above issues and decided to oppose the introduction of pentavalent vaccine in Tamilnadu's UIP as a pilot basis. The committee also discussed the mode of the campaign and decided that more focus should be given to change the policy through advocating with the public health department officials and bureaucrats and with media. We also need to identify other allies including Trade Unions and Medical Representative Unions as well as academics in the initial phases. The committee also decided to give less priority to mass level campaign at the present juncture present since the issue is complicated, since people see the injection being used in the private sector at a very high cost Thus thus the opposition to its free provisioning in the public sector need to be argued carefully with people. This is especially crucial where there is such a high demand and acceptability of injections / vaccines in general. The committee also decided to hold press meeting in six parts of the state viz., Chennai, Vellore, Madurai, Kanniyakumari, Tiruchy and Dharmapuri. Rakhal and Ameer would draft a note for discussion on this issue.

As the next agenda the committee had a discussion on the Koodankulam Nuclear plant The committee had discussion on the rationale behind the people's demand to close down the nuclear plant. Two major arguments were taken up for discussion before it was decided to support the people's struggle to close the Koodankulam Nuclear plant.

1. The safety of the plant – this issue was discussed in length. While it was –and by argueding that there were no incidents of disasters in other Indian Nuclear plants and the plants are declared as safe, other –but few members pointed out had quoted the the international experiences of closing down the nuclear plants and the fact of nuclear plants

in general ~~are have never been not~~ proved as "not hazardous". The wastes ~~of produced by these plants for example are~~ remains hazardous forever.

2. Opposing the plant at ~~thesuch a latest stage~~ – and possible motivation behind this ~~The sudden uprising of people against the plant. - It was pointed out that The argument was we had spent more than 13000 crore rupees in the construction of the plant so far, thus so much money will be wasted and how can we stop it now and the counter arguments were~~ However it was also pointed out that (especially in the present era of scams) ~~m~~Money cannot ~~by~~ be the criteria for determining people's life and safety. It was also pointed out that while a number of NGOs / movements had opposed the plant right from the beginning and there was no initial popular support, it was suspicious what the real motivation of the present leadership of the popular struggle is. It was discussed that and realizing the hazards at ~~theany stage by the people cannot in anyway reduce the need ofthe opposing the plant or support the peoples struggle~~popular support. ~~last minute is not suppress the issue of safety in any front. Safety and issues of life and death cannot be decided on the basis of when in the life cycle of a project these issues are raised.~~

Based on the detailed analysis MNI steering committee had decided to give a public statement of demanding to put on hold the commissioning of the nuclear plant and support the people's struggle and its demands.

#### Attendence

1. Mr. Arokiam Puspharaj - VHA
2. Dr. Kulanthuivel Pandiyan - INSE
3. Mr. Martin - FI-DOH
4. Mr. Francis - CHAT
5. Mr. Shankar - DIVANI
6. Dr. Chandra DAS - CBR & INHDF
7. Dr. Shanmuga Velayudham - ENFORCES
8. Ms. Saulina Arnold - TNVHA
9. Mr. Ameerkhan - CFI - SOCHARA
10. Dr. Rakhal - Permanent invitee on behalf of National Coordination Committee of ISA
11. Prof. Ramanavickam - INSE - Special invitee
12. Mr. Venkatesan - SOCHARA - Special invitee

Mr. Dhandapani from Adiyantam could not attend the meeting.









## **Report of State level Participatory Assessment and Network Strengthening (PANS) meeting of JSA, Odisha**

With the background completion of 10 years of Jana Swasthya Abhiyan, Odisha, we have organized a State level review meeting of JSA, Odisha at BGVS office, C/2, HIG, Baramunda, Bhubaneswar on 29<sup>th</sup> October 2011 at 3 PM to strengthen JSA as a platform of health activities and to make JSA more effective.

Meeting was presided by Mrs. Sarajini, Joint convener National JSA. Total 20 members participated from 7 networks and 13 JSA partners organization.

### **Objective of the Meeting was:**

To assess and analyze the past and present state JSA activities

To discussion on the National JSA activities and participation in National JSA workshop to be held in Nagpur.

To develop future strategies for further strengthening the network of JSA in Odisha

To identify various issues and concern in the public health system in the state

### **Agenda of the meeting was:-**

History of JSA and background of PAN process

Report of past JSA state activities

Participant comments on future activity and strengthening network

Delegation for Nagpur meeting

Future action plan

Mr. Gouranga Mohapatra, State convener, JSA, Odisha welcomed the participants followed by the self introduction of the member participants. After the self introduction Mrs. Sarajini briefly presented the genesis, history and national activities undertaken in last 10 years. She also discussed the purpose of Participatory Assessment and Network Strengthening PAN at state as well as at national level. After that Gouranga Mohapatra presented the structure of jsa Odisha, different committee and function of these committees, secretariat function, program components and detail year wise activities undertaken by Odisha JSA with involving national and state level JSA partners organization/networks. He also informed this year Odisha JSA is going to undertake an in-depth study of 6 years of NRHM in the state, where 30 individual organization are involved in the study in 30 district of Odisha with the support from BHVS and CMAI. For this purpose a state level orientation training was organized at Bhubaneswar from

23<sup>rd</sup> – 24<sup>th</sup> October 2011. The study report will be shared in January 2012 in the state level sharing workshop and a future advocacy plan will be prepared. He spoke that Odisha jsa has modified the national PAN format and circulate among the member organization. Some organization has sent their comments and other yet to be sent. After his presentation the members discussed on the following health Issues:-

- Issue of Generic drugs
- Mamota scheme
- Strengthening health care in community level
- More focus on Prevention
- Malnutrition should be focus
- Advocacy on health right
- Focused on community mobilization
- Convergence of different department
- Capacity building of PRIs on health
- Address the health of urban slum
- Organize health camp
- Focus on health of school children and linkage with SSA
- BCC in remote area
- Capacity building of Ayus doctor

#### **Organizational issues discussed by the member**

- JSA should have own office may be request to Government
- District and regional committee should be strengthen
- Involve new organization
- Membership fees can collect
- Identify other organization and involve in jsa
- **Capacity building of JSA member**
- Develop a resource group on health
- Revive quarterly news letter “ Gana Swasthya Khabar” and wide circulate
- Support from national JSA
- Regular JSA meeting with host by different organization

Nagpur delegates were also discussed and following members are decided to attend Nagpur meeting

- i) Mr. Gouranga Mohapatra, State convener, JSA, Odisha
- ii) Member from OVHA
- iii) Mr. Subimal Panigrahi



### Future activities

- 1) State level study on 6 year of NRHM in Odisha within January 2012
- 2) State level Women health tribunal by presenting women health denial cases with SAMA, AAINA, NAWO, AIDWA etc in December 2011
- 3) Take up advocacy and entitlement issues of health denial victims and vulnerable
- 4) Malnutrition issue with involving right to food and child health now
- 5) Work for effective GO-NGO-PRI coordination for next phase of NRHM
- 6) Activities based on Right to health would be taken up
- 7) Advocacy on Mental Health with Basic need India
- 8) Revive of quarterly news letter " gana Swasthya Khabar"
- 9) Strengthen Community Monitoring
- 10) Conduct public hearing and social Audit in different area
- 11) Health awareness campaign
- 12) Capacity building of member organisation
- 13) Advocacy for people Health Policy

### Members attended the meeting-

Participant of TATE LEVEL REVIEW MEETING OF JSA, ODISHA FOR (PANS)					
SL. NO	NAME	ADDRESS	ORGANISATION	CONTACT NUMBER	E.MAIL ADDRESS
1	Preeti	B-45, IInd floor, Shivalik, Main road, Malvya nagar, New Delhi-17	SAMA- Resource group for women of Health.	09811949444	samma.womens health@gmail.com
2	Sarojini	B-45, IInd floor, Shivalik, Main road, Malvya nagar, New Delhi-17	SAMA- Resource group for women of Health.		samma.womens health@gmail.com
3	Pragyan paramita Bastia	N6-474, Jayev vihar, BBSR-15	NAWO	9438482717	prajna_bastia@rediffmail.com
4	Usha rani Behera	c/2 Hig baramunda, bbsr	BGVS	9437189464	behera_usharani@yahoo.com
5	Sneha Mishra	Jaydev vihar, 70/3530, BBSR-13	AAINA	9437017967	aaina50@hotmail.com Also the member of NAWO and convener of "We can"
6	Sashiprava bindhani	NAMHHR/D-4, Bijaylaxmi apartment, Tankapani road, BBSR	NATIONAL ALLIANCE OF MATERNAL HEALTH AND	0437330808	sashi.bindhani@gmail.com Also the convener of wadana todo Abhiyan

			HUMAN RIGHTS.		
7	Blorin ku Mohanty	Bgvs,c 2,HBeolony Baramunda	BGVS	9437111204	blorinm@yahoo.co.uk
8	Bijaya ku Das	Bgvs.Jaipur	BGVS	9439560842	kcjaiput@gmail.com
9	Anuja Naik	plot no-20a,Nilakantha nagar,Nayapalli,Bhubaneswar	CHRISTIAN MEDICAL ASSOCIATION OF INDIA.	9778055746	anuja.cmai@gmail.com janaik52@yahoo.com
10	Mrutanjay Nayak	plot no-20a,Nilakantha nagar,Nayapalli,Bhubaneswar	CMAI	9437628047	mnayak.unai@gmail.co
11	Sadasiv swain	CCWD,HIG/93,lumbini bihar,CS Pur,BBSR-21	CCWD	9668741913	ccwdsadasiv@yahoo.co <b>Convener of Forum against child exploitation (FACE)</b>
12	Gouranga ch Mohapatra	CL-38,VSSNAGAR, bhubaneswar	JSA	9437036305	gouranga2k@yahoo.com
13	Hrishikesh panda	Ankul, Jaipur	COPHEE	0937853696	copheel@yahoo.co.in
14	S.panigrahi	BBSR	EDP TRUST	9777177207	edporissa@gmail.com
15	Manoj ku sahu	BISHWASS, DEOGARH	BISHWASS	9438135130	
16	Nimain Ray	AYS.Jaipur At/po-Abhimanyu balia,Jaipur-755005	AYS	9437386074	ays_jaipur@rediffmail.
17	Jagannath Jhatagy	RCDC,A168,first floor sahidnagar, BBSR	RCDS	9337102146	jagannath012yahoo.com
18	Ranjit swain	Chale chalo Rajnagar dist-kendrapada, pin-754225	CHALE CHALO	9439400352	chalechalo@rediffmail.
19	S.n pattnaik	Public health society,Delhi	PHRN	09437106907	chhabipattnaik@gmail.
20	Rajkishar Mishra		State convener Right to food		



## Brief report of MPJSA meeting held on 23<sup>rd</sup> Oct 2011

Meeting of MPJSA was is organised on 23<sup>rd</sup> Oct 2011 at MPBGVS office at 11 AM. Meeting was presided over by Prof Udai Jain, President, MPVS.

Agenda discussed-

1. History of JSA and back Ground of PANS.
2. Brief reporting from members on questions of PANS process circulated by NCC. Views on network working and activities for future.
3. Participation of other organisations in MPJSA.
4. Core Group formation
5. Delegated for Nagpur meeting.
6. Meeting is held in good presence and majority of experienced and long associate members had participated in the meeting.

Dr Ajay Khare, reported briefly about formation of JSA, its activities and PANS process to participating members. It is felt that MPJSA has done lot of activities but due to business preoccupation of Ajay Khare being appointed as Deputy Director, NRHM of Dr Ajay Khare coordination has become weak from some time. It was expressed that Between two large activities continuous process is required to keep members active. Members reported their activities with MPJSA and other health related activities in their area. Majority of members had participated in PHA 1- 2000, Jan-Sunwai, PHA 2 -2007, PRHW and Community Monitoring of Health Services, press Conferences etc.

Following decisions were taken in the meeting-

1. It is decided to contact inactive MPJSA members.
2. Organisations, networks who are not currently member of MPJSA will be contacted for MPJSA membership. ASHA USHA sanghatana, Jan Adhikar Manch, Manav Adhikar Forum, Angan-Wadi Sahayika Union, MP Medical Officers Association etc will be contacted for participation in MPJSA. List will be prepared for Regional meetings which will enable other organizations to associate with MPJSA.
3. Activities based on Right to health would be taken up.
4. Coordination with Right to Food Campaign will be strengthened.
5. Newly formed Maternal Health Group will be involved in MPJSA
6. Regional Meeting will be held at Gwalior, Rewa, Indore, and Jabalpur. District organisations will be invited in regional meetings.
7. Following activities will be taken up by MPJSA
  - i) NRHM review.
  - ii) Review of implementation of PCPNDT act.
  - iii) Campaign to save girl child.
  - iv) Malnutrition issue will be taken up.

v) With Government we will have critical engagement.

vi) Social Determinants of Health.

vii) Maternal Health follow-up along with the separate group that has been active the last 3-4 months

8. Core group is formed to coordinate activities with following members-

- i) Dr Ajay Khare
- ii) Mr Amulya Nidhi, Shilpi Kendra, Indore
- iii) Father Mathews, CHAMP
- iv) Dr Shailendra Patne, MPVS
- v) Mr Prasanna Saligram, CPHE
- vi) Dr Rahul Sharma, MPBGVS
- vii) Mrs Sandhya Shailey, JMS
- viii) Mr Shailendra Sharma, MPMSRU
- ix) Ms Sudha Tiwari, Anupama Education Society, Satna

Dr Rahul Sharma will coordinate core group.

9. All members will be requested to send PANS questionnaire up to 28<sup>th</sup> Oct. Team will analyze and will prepare report.

10. Next meeting will be held on 31<sup>st</sup> Oct 2010 at 5 PM at MPBGVS office.

11. Nagpur delegates were also discussed and following members are decided to attend Nagpur meeting-

- i) Dr Ajay Khare- NCC member
- ii) Ms Asha Mishra- On Behalf of BGVS

MP delegates

- i) Dr Rahul Sharma
- ii) Dr Shailendra Patne
- iii) Mr Amulya Nidhi
- iv) Ms Ragini Mishra
- v) Ms Nidhi Shukla
- vi) Mr Prasanna Saligram( May be from CHC group)
- vii) Delegate from SATHI CEHAT

Report is prepared and circulated on behalf of MPJSA core group.

Following members have attended the meeting-

No.	Name	Organization	Contact No./Email
01.	Prof. Dr. Uday Jain	MPBGVS/M.P.V. S./CRO	9425013223
02.	Dr. Ajay Khare	MPVS/JSA	9425004269
03.	Ms Asha Mishra	BGVS	9425302012



04.	Dr. Shailendra Patne	MPVS/JSA	9425015929
05.	Fr. Augustine	MPSSS/CHAMP	9406617895
06.	Mr Prasanna Saligram	CPHE	9977216619
07.	Mr Prabhu Sharan	Mission Hospital, Chhatarpur, CPHE Fellow	9425879171
08.	Mr Kedar	Gram Sudhar Samiti, Sidhi	9424349796
09.	Ms Ragini	Geam Sudhar Samiti, Sidhi	9977510158
10.	Fr. Mathew	CHAMP/MPSSS	9425013223
11.	Ms Sudha Tiwari	Anupama Education Society, Satna	9424440075
12.	Dr. Apra Vijaywargiya	Vikas Samvad	9425377353 apraloz@gmail.com
13.	Ms Deepa	Vikas Samvad	9893350554 deepapohankar@gmail.com
14.	Ms Shilpa Jain	MPBGVS/MPVS/CPHE Fellow	9425718308
15.	Md. Irshad Khan	CPHE	9926830245
16.	Mrs. Neera Soni	CID, Shivpuri	8305811198
17.	Mr Umesh Vashishtha	MAF/CDS.	9425111198
18.	Ms Sandhya Shaili	AIDWA	9425008077
19.	Ms Neena Sharma	AIDWA	9425008078
20.	Mr. S.R. Aazad	MPVS	9425009257
21.	Ms Nazra	CPHE, Tikam Garh	9424343427
22.	Ms Shabana Khan	MPBGVS/CPHE	9425187396
23.	Ms Nidhi	MPVS/CPHE	9407074256
24.	Ms Aarti Pawar	CPHE Fellow	9893433405
25.	Ms Tarannum Mewati	NIWCYD	9827267544
26.	Mr Waseem	MPBGVS	9827267544
27.	Mr Deepak Bhatt	PRS	9826306365
28.	Mr Anil Dhiman	MPBGVS	9893809950
29.	Dr Rahul Sharma	MPBGVS/JSA	9826281101





**Participatory Assessment and Network Strengthening (PANS) Questionnaire****Madhya Pradesh Jan Swasthya Abhiyan (MPJSA)****1) Participation in activities of JSA**

Which activities of JSA, coordinated at the national level, have you been associated with (you can add your comments of the role you played in these activities).

**a) Pre-National Health Assembly 1 (held in Kolkata in December 2000) activities in 2000**

- Coordinated, Organized & Participated in pre-assembly activities like PHC/CHC level survey, District level information gathering & State Health Assembly.

**b) National Health Assembly 1 in Kolkata in 2000**

- From MPJSA more than 60 delegates were participated in Kolkata Assembly and 5 delegates attended the international assembly Dhaka.

**c) Right to Health Public Hearings (Jan Sunwai) in 2004-2005**

- Participated in Jansunwai and collected cases from Morena & Chindwada for the same. Along with this few cases of denial of health care also presented in this Jan Sunwai.

**d) NRHM watch in 2007-2008**

- Actively participated in NRHM watch process and collected information from 20 Districts of M.P.
- Published the report also on outcomes of watch.

**e) Pre-National Health Assembly 2 (held in Bhopal in March 2007) activities in 2007**

- Regional Health Assemblies
- State Health Assembly
- Raised the Gas Tragedy issues
- Awareness campaign on Right to Health

**f) National Health Assembly 2 in Bhopal in March 2000**

- MPJSA hosted the assembly from 13-15 March 2007 in Bhopal. More than 2000 delegates were participated in assembly.

**g) Any other (including state JSA programmes), please list:**





- Press conference and seminar on the occasion of World Health Day, every year.
- Release Global Health Watch-2 in Gandhi Medical College, Bhopal
- Discussion on the draft of National Health Bill.
- Survey and Status report on working situations of DAIs.
- Pre Election Dialogue on the issues of health with political parties.
- Disseminated information and organized training on Intra-dermal use of Rabies vaccine.
- Awareness campaign against unethical drug trial regarding the prevention of cervical cancer.
- Created awareness among the rural people about the health rights and taught them how to get the health rights as well as the benefits from health schemes.

## **2) Experience of participating in JSA activities**

Please write a few lines of the experience (positive or negative) of participating in activities of the JSA, including suggestions about how the activities could be better organised.

- Reactivation of organizational components of JSA and approach to new organizations and individuals.
- Required continuity in JSA activities
- Dialogue with experts/ movements/NGOs, Advocacy with administrative officers and programmatic involvement of common peoples is required.
- Critical relationship with Government.
- Will Organize many programmes on social determinants of health.

## **3) Organisational Structure and co-ordination in JSA**

Give your opinion about the organizational structure and co-ordination within JSA in your state at present. Discuss how it can be improved and strengthened.

- Regularity in programmes/activities/meetings.
- Orientation of individuals and organizations on health and its various determinants.
- Required full time coordinator for JSA in M.P.
- Extension or decentralization of organizational structure and activities at regional and district levels particularly.
- Try to raise the local level issues related to health system.

## **4) Activities of your organisation in the health sector**

List activities of your organisation (or as individual) in the health sector – this includes activities beyond those co-ordinated by the JSA





- a. MPBGVS: Campaign against MMR/IMR/, Training on health in 175 Panchayats and among SHGs, etc.
- b. MPVS: Campaign against Malnourishment, Trainings for health activists, Activities on tribal health issues, Health and Hygiene campaign among women, etc.
- c. Gram Sudhar Samiti-Sidhi: Meetings of VHSCs, Organized village health and nutrition days, Activities with ASHA, Anti-Malaria Camp, Motivational campaign for Immunization, Campaign for under nourished and mal nourished children's, etc.
- d. CHAI: Rural health assemblies, Village Health Rallies, Memorandum to district collector on health issues, etc.
- e. Asha Gram Trust-Badwani: Community based mental health and disability program, awareness program on tuberculosis & HIV/AIDS, Rehabilitation of Leprosy cured persons, etc.
- f. Anupam Education Society-Satna: Works on activities of Rogi Kalyan Samiti, Activities on prevention of malnourishment, etc.
- g. AIDWA: Campaign against MMR/IMR, Activities on awareness related to violence against women, etc.

#### **5) Activities of your organisation in relation to NRHM**

Has your organisation been associated in any programmes of the NHRM? Discuss from the list below or add if there are any others:

**a) Community Monitoring:** MPBGVS, MPVS, Gram Sudhar Samiti- Sidhi

**b) Training of ASHA:** MPVS, Ashagram Trust, MPBGVS (Build organization of ASHA in Gohad Block of Bhind District), Anupam Education Society.

**c) Formation of Village Health and Sanitation Committees:** MPBGVS, MPVS, Gram Sudhar Samiti-Sidhi, Anupam Education Society.

**d) Any others (list and discuss)**

MPBGVS: Representation in State ASHA Mentoring Group.

MPVS: Representation in State ASHA Mentoring Group & Campaign on anemia among adolescent girls in Bhopal.

Gram Sudhar Samiti: Working with CPHE, Bhopal in the form of community health fellow.





## **6) Future activities of JSA**

List the activities, in your opinion, that can be a priority for the state JSA and the national JSA.

- 7 Years analysis of NRHM and its regular monitoring
- Campaign for decreasing MMR/IMR & Starts the process of Maternal Death Audit
- Campaign against Malnourishment
- Campaign for availability of drugs.
- Campaign for National Health Bill
- Campaign against Adverse Sex Ratio
- Campaign on Urban Health
- Rural Health Watch

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# Participatory Assessment and Network Strengthening (PANS) Questionnaire

## Madhya Pradesh Jan Swasthya Abhiyan (MPJSA)

Respondents → Points of PANS ↓	MPBGVS, Bhopal	MPVS, Bhopal	MPSSS/CHAI, Bhopal	Anupam Education Society, Satna	Gram Sudhar Samiti, Sidhi	Asha Gram Trust, Badwani
01. Participatio n in JSA Activities A. Pre NHA-I	Health Status survey in 20 districts/ Active participation in Pre NHA-1/ Organized State Health Assembly	Participated in pre assembly activities/collected information at district level/coordination of state level activities/ Organized State Health Assembly	--	Meetings & Survey at district level	--	--
B. NHA-I	20 delegates. 02 delegate in Dhaka	10 delegates. 1 delegate in Dhaka	--	--	--	--
C. Right to Health Public Hearing	Participated & Played important Role	Participated & collected information from Chindwada & Morena. Presented 2 cases of health denial.	--	Peoples mobilization	--	--
D. NRHM Watch	Health Watch Survey in 10 districts	State level coordination of process/Survey in	--	Survey in district	--	--





			2 districts. Published report of health watch					
<b>E. Pre NHA-II</b>	3 Regional assemblies & Coordination of State Health Assembly	Coordination of State Health Assembly/ Submitted Bhopal Gas Disasters report.	Coordination of State Health Assembly/ Submitted Bhopal Gas Disasters report.	--	Block level meetings/ District level Meetings	--	50 Peoples were participated/ Organized Mental Health & Disability Forums.	
<b>F. NHA-II</b>	Coordination of NHA-II	Coordination of NHA-II	Coordination of NHA-II	Participated	Actively participated	--	Participate in NHA-II	
<b>G. Any Other</b>	Seminars, Press conference on WHD/ Discussion on National Health Bill/ Pre-election campaign for health	Release Peoples Health Watch –II in G.M.C. Bhopal/ Discussion on National Health Bill/ Study on the status of DAIs/ Pre-election campaign on Health with political parties/ Campaign and training on intra-dermal Rabies Vaccination in G.M.C. Bhopal/ Campaign against unethical drug trial regarding cervical cancer	Release Peoples Health Watch –II in G.M.C. Bhopal/ Discussion on National Health Bill/ Study on the status of DAIs/ Pre-election campaign on Health with political parties/ Campaign and training on intra-dermal Rabies Vaccination in G.M.C. Bhopal/ Campaign against unethical drug trial regarding cervical cancer	Awareness creation on Right to Health & Health programs among rural peoples	--	--	Participate in many State level meetings/ Participated in Indore JSA Meeting.	
<b>02. Experience of Participating in JSA</b>	Organizational Strength/ Proper management of JSA functioning/Emphasis	Continuity in activities/ Advocacy with Administrative	Proper and adequate setups required	Regularity required in activities/ Information	Proper information of programs/ Strengthen Communication	Proper information dissemination is necessary		





Activities	on social determinants of health/ Liaising with others	officers/Dialogue with experts/ Programs on directly related issues of common person/ Critical relationship with Government/ Reactivation of inactive members and organizations		sharing/ Formation of core groups from state to block levels.	process/ Proper planning also essential.	
03. Organizational Structure & co-ordination in JSA	Extension in organizational structure/ Full time coordinator/Regular activities	Full time Coordinator is essential/ For active participation of others continuity in activities and proper communication is recommended.	For strengthening of the JSA regular & joint programs is necessary	Organizational Strengthening is necessary/Regular discussions and meetings also required/Distribution of responsibilities.	Networking at district level with other organizations/Reputed organization will take responsibilities of JSA at divisional level and organize regional meetings/ Involve village, panchayat level representatives in JSA/Issue based core group at district level.	Structural Decentralization of JSA/ Proper Secretariat of JSA for better functioning.
04. Activities in your organization in Health sector	MMR-IMR Campaign/ Health Training in 175 Panchayats/ Health Training for SHGs members	Awareness program on Malnourishment/ Health Trainings in Durg, Bilaspur, Teekamgarh & Chindwada/ Tribal	Rural Health Assemblies/ Health workshops in rural areas/Health Rallies in rural	Active on Health issues/Worked for the activating R.K.S./Malnourishment/ Women health	Meetings of VHSCs/Organized Village Health & Nutrition Day/Meetings with ASHAs & their capacity	Community Based Mental Health and Disability Program/ Tuberculosis, HIV-AIDS, Leprosy awareness Program.





		Health Issues/ Health & Hygiene Trainings for women	areas/ areas/		building/Anti- Malaria Camp/Motivation program for women regarding Immunization/Iden tification of Malnourished children and provided nutritional counseling for their parents.	
05. Activities of your organization in relation to NRHM A. Community Monitoring B. ASHA Training	In 3 blocks 9 PHCs' and 45 villages of Bhind	Coordinated Community Monitoring of Health Services Program in 5 Districts of M.P.	--	--	In 3 blocks 9 PHCs' and 45 villages of Sidhi	--
	Build ASHA's organization in Bhind	Pre testing of ASHA Module- 5/ASHA Training in Chindwada	--	Participated	--	Venue Provided for ASHA training
	In 45 Villages of Bhind and in other districts also.	45 VHSCs in Chindwada	--	Formed	Formed by GSS in 45 villages	Involved in VHSC formation during the process of Community Monitoring.
D. Any Other	Representation in State ASHA mentoring group	Campaign against Anemia among adolescents girls	--	--	Involve as Community Health Fellow in CPHE, Bhopal	--
06. Future activities of JSA	7 Years of NRHM/ Campaign on MMR &	Monitoring of NRHM/	Regular Information	--	Maternal Death Audit/	Organizational Strengthening is





	IMR/Adverse Sex Ratio/ Community Monitoring/ Social determinants of Health/Urban Health	Malnourishment/ Women Health/ Availability of Medicines	sharing/ State level reflections sessions/ Rural Health Watch/ Work among ASHA & AWW/ Regular regional meeting of JSA		Strengthening of FRU Services/ Strengthening of IMNCI Activities	required.
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## PANS PROCESS REPORT

### JSA UP

#### Self Assessment

#### Discussion

Partner organizations of all those who have been associated with JSA – in the past or in the present.

Discussions among core committee members were held from time to time.

Discussions with Experts from SGPGI I MS, CDRI, Medical University, CIMAP, PMS Association, Anganwadi Unions, ASHA and ANM Unions and Bar Association members.

#### Two meetings at state level

First on September 3, which was attended by Dr Vandana Parsad, as National JSA Representative and participants from the state.

Second was held on November 2. The meeting was attended by representatives of 16 organizations and some individuals some of them medical and development professionals and others university students.

#### 1) Participation in activities of JSA

8 organizations taken part a) National Health Assembly 1 (held in Kolkata in December 2000) in assembly.

9 organizations were associated with Public Hearing of 2004-05.

6 organizations actively participated in NRHM watch 2007-08.

5 organizations and number of individuals actively participated in the National Health Assembly 2 in Bhopal in March 2007

#### Experience of participating in JSA activities In Uttar Pradesh

#### Organizational Structure and Co-ordination in JSA

Functional coordination group JSA. suggested the following:

A larger steering group formation is required.

A Secretarial assistant is required for JSA secretariat (a volunteer)

More frequent meetings should be held , may be once a month

#### Activities of JSA members organization in the health sector





Major activities of the organizations are

Adolescent girls health

Women and Child health Rights

Awareness on Health Care issues, entitlements etc.,

Female foetecide

Nutrition

**Activities of your organisation in relation to NRHM**

**Future activities of JSA**

Orientation of new organizations on JSA objectives.

Organizing workshops at regular intervals on state specific issues.

More interaction with member organizations.

Folders be written on our charter of demands for distributing to political parties before forthcoming elections.

Share outcomes of works with member organizations

Work united on state specific issues such as Japanese Encephalitis, Maternal health, privatization of health services, NRHM irregularities in the state.

**At National Level:**

Capacity building of state organizations need to be taken up as an urgent issue.

More sub committees to be formed with subject/area specific responsibilities for better outcomes.

Regional level coordination may also be effective for better functioning.

Thank you





## Jan Swasthya Abhiyan Delhi (JSAD): Brief Update (2010-2011)

### Background

The JSAD group began meeting in April 2010 following a gap of over 2 years. The April 2010 meeting sought to bring together old partners as well as newer groups towards collectively planning future direction for campaigns / activities as well organizational issues. While regular meetings followed till August 2010, thereafter there was a gap again till October 14, 2011 when a few JSAD partners met. Thus, no sustained collective campaigns / activities have taken place during this last year and a half.

### Activities / Campaigns planned

- While several health issues in Delhi that could be taken up by JSAD through campaigns / actions were discussed during the initial meetings in 2010 - including PPPs, Insurance, health infrastructure, availability and quality of health care, access to health care by different marginalized communities, etc.
- It was decided to focus on the campaign on *Universal access to free OPD treatment* as a starting point. A national level campaign on the issue had been initiated by JSA and it was also perceived as an important concern / issue at the Delhi level.
- A study of public health facilities in the context of availability, access, quality, systems of supply / procurement / distribution was initiated, towards informing and strengthening the campaign. The study was also seen as a way of collective action towards reactivating the JSAD.
- However, the interest and involvement seemed limited to a few partners and could not be sustained and the study did not take place.

### Future plans

#### Campaigns / Activities

- Future meetings to identify and deliberate on specific issues that are relevant to Delhi in addition to organizational issues. For e.g., the next meeting will include a discussion on cash transfers by a resource person from the Right to Food campaign.
- Community based initiatives / action to go hand in hand with research / study processes.
- Dissemination of information of events, initiatives and campaigns by partners, so that other JSAD members can participate /be involved.

### JSAD: structure, organisation, functioning

- Despite the irregular participation and challenges in collective functioning, it was felt that JSAD should be reactivated and can play an important role in advocacy for health rights in the state.
- The process of PANS however was not possible as it was felt that the JSAD had not functioned as a collective in about 3 years. One completed PANS format was received (Attached here).
- ★ The need to re-look at the structure of JSAD and explore options for effective functioning – the possibility of a state coordination group that comprises representation from diverse organisations / groups is suggested towards strengthened coordination.
- ★ Meetings to be regular - monthly / bimonthly; to ensure that there are no long gaps.
- Sama had taken the responsibility of coordination / secretariat during this past year. Sama has expressed inability to continue beyond November 2011 as secretariat; Prasar has come forward to coordinate (to be discussed in the next meeting).





# Participatory Assessment and Network Strengthening (PANS)

## Self-review Report of Jan Swasthya Abhiyan, Rajasthan

Jan Swasthya Abhiyan Rajasthan, the Rajasthan state chapter of JSA recently organized a meeting with the JSA members of the state to discuss on major health issues of the state and to discuss and initiate the PANS process. The meeting so held on 29<sup>th</sup> September 2011 marked participation by representatives of organizations associated with JSA Rajasthan, Dr. Amit Sengupta representing National JSA as well as some govt. officials. Dr. Samit Sharma, the then Mission Director NRHM of the state chaired the meeting. The meeting was significant as it was being held at a crucial time, just 4 days before the govt. was to initiate the free medicine scheme at all govt. health facilities. The major agenda of the meeting was to:

- Understand the free medicine scheme and to examine and analyze it through a public health perspective.
- To identify strengths and weaknesses in operationalisation of the free medicine scheme, and to carve out strategies for overcoming the weaker areas and to strengthen its implementation.
- To evolve strategy for better monitoring of health services in the state, especially through community participation and citizen involvement.
- To introduce JSA Rajasthan members to the PANS process and to discuss on strengths and weaknesses of the Abhiyan in the state.

Although this was not the first time that the PANS was introduced to the JSA members, the meeting greatly helped in providing broader perspective about the whole process, its significance and deriving their feedbacks and suggestions on crucial issues related to functioning and strengthening of JSA in the state. The mails were earlier circulated amongst the state JSA members seeking their feedbacks through the PANS format (attached at the end of the report), although it brought about negligible participation by



the members initially. The discussions held on PANS process during the meeting significantly helped in deriving inputs and suggestions from the state JSA members and further boosted participation of JSA associates in the state in filling up the PANS format.

### **The PANS Process in Rajasthan:**

The PANS process in the state essentially began with the 29<sup>th</sup> Sep JSA Rajasthan meeting held in Jaipur. The meeting introduced the JSA members to the significance of the PANS and how their participation in the process was vital. The meeting also evolved discussions on the strengths and weaknesses of JSA Rajasthan through a brainstorming session, and derived suggestions and feedbacks from the participants to further strengthen JSA in the state and evolve greater participation of the JSA members and the community across the state in its campaigns and activities.

Thereafter the meeting, the PANS format was once again circulated amongst the JSA members through mails. They were requested to send in the filled up formats either through mail or by post. Continuous follow ups with the members helped receive feedbacks from if not all, but most of the organizations which have been a part of JSA Rajasthan and have been involved in its various activities. Some of the organizations were comparatively new associates of JSA, but had some fundamental feedbacks and suggestions for its further strengthening which is appreciable.

### **Major Responses and Feedbacks Received through PANS:**

#### **Health as a Priority Area for JSA Members:**

Most of the organizations associated with JSA Rajasthan have been directly or indirectly associated with health activities. Many of the organizations which are directly associated with health are largely involved in activities related to health education and mass sensitization such as creating health awareness in the community, training of frontline workers such as ASHAs and AWWs, training and strengthening of VHSCs, combating female feticide, adolescent health, HIV & AIDS, malnutrition, quality of health care services, maternal and child health etc. Other organizations which have been indirectly associated with health have been working on various rights based issues such as right to food, the BPL issue, NREGA, dalit rights, land rights, natural resource management, domestic violence and women empowerment.



Thus the membership is a mix of organizations with health as direct focus for some and indirect focus for others.

### **Participation in National and State JSA events:**

It was derived from the feedbacks received and discussions held that the participation of JSA Rajasthan members in national events has been comparatively low and there is a possibility of evolving greater participation of members in national events and programs. Few organizations participated in national events and most of the others remained limited to preparatory activities at state level prior to organization of these events. State level campaigns and activities organized by JSA Rajasthan such as campaign against female feticide, campaign on right to health, campaign for free treatment however marked greater participation and involvement of member organizations. Short courses on Health Equity and Health Rights and various consultations organized on health issues by JSA from time to time, involved greater participation of members. Most of the members suggested that they would like to keep themselves more updated with national JSA events, programmes, discussions and decisions and would appreciate if participation in greater numbers is called for from the state.

Many of the organizations also specified that although they had the opportunity to participate in national events they could not do so due to prior engagements and commitments. Priority work of their respective organizations somehow at times prevented their participation in these events.

### **JSA Rajasthan Structure and Co-ordination:**

Feedbacks from most of the JSA state members suggested that they were satisfied with the structure and coordination of JSA in the state. However there were suggestions from a few who talked about restructuring of JSA in the state by introducing specific designations such as those of president, secretary etc within JSA which would provide it a more organizational and structured shape, which would further strengthen the abhiyan and its functioning. However, there were contradictory suggestions from some who believed that the abhiyan must function in a loose structured manner and more like a mass movement.

There were suggestions on greater involvement of member organizations and community members in JSA activities which are provided at the last section of this report.

#### Priority Issues which should be taken up by JSA in Future:

Most of the JSA Rajasthan members suggested the following major issues which should be taken up as priority issues by JSA:

- Right to free treatment campaign must be taken up at both state and national level in order to make govt. health services accessible to all.
- Now that Rajasthan govt. has initiated free medicine scheme at all govt. health facilities, strict monitoring system should be created for the same through involvement of civil society organizations and community members.
- Campaign to put an end to user fee at govt. health facilities.
- Campaign for health as a fundamental right
- Campaign against marketisation of health services
- Campaign against privatization of health services. Private practice by govt. health service providers should be completely banned.
- Campaign for quality assurance of health services
- A strong citizen based monitoring system for health services should be created in the state. Continuous assessment, reporting and sharing on health services being provided under NRHM
- Issues related to domestic violence should be strongly taken up
- Combating female feticide, creating mass awareness on the issue and implementation of PCPNDT act
- NGO's participation in creating awareness and monitoring of free distribution of medicines needs to be recognized by the govt.
- Strengthening of VHSCs and enhancing their roles



- Availability and accessibility of health services at primary health care level should be assured through continuous monitoring and performance assessment of facilities
- Capacity building and sensitization of health service providers on public health issues, social determinants of health and medical ethics

#### **Major Weaknesses and loopholes:**

- Organisations associated with JSA since long time now do not have health as a priority focus in their agenda. This makes them dormant and inactive.
- Lack of resources for carrying out various activities and campaigns
- Less linkages with other JSA state chapters and discussions and decisions at national level.
- Some of the JSA members due to their prior engagements and organizational responsibilities have been irregular in participation in meetings and activities and this affects JSA activities
- Lack of participation by govt. officials in JSA meetings

#### **Suggestions and strategies for further strengthening of JSA:**

- District level JSA chapters and units should be created across the state
- Greater awareness about JSA needs to be created amongst social activists, NGOs, academicians, community members and other stakeholders.
- Role of civil society organizations in planning and formulation of schemes should be recognized by the govt. JSA should have greater involvement in these processes.
- Continuous and long term activities and campaigns should be initiated
- Participation of organizations and community members needs to be increased

- Dormant organizations and members should be given specific responsibilities so that they get more active and participative
- Resources for regular and long term activities needs to be arranged
- Dialogues with govt. should be increased
- More visits and interactions with other JSA state chapters should be promoted.
- Representation of govt. officials in JSA meetings and activities should be enhanced.



## History of Gujarat JSA (Draft- To Be Added Onto)

Compiled by Vijeta Jain, Suhaag Jani (Deepak Charitable Foundation) and Renu Khanna (SAHAJ)  
Sept. 24, 2011

As in other states, Gujarat JSA was formed in 2000 before the first People's Health Assembly in Dhaka. After an intense preparatory process, Gujarat JSA held its Jan Swasthya Sabha on Nov 11-12, 2000. It was attended by around 700 persons and the outcome was Charter of Health of the People of Gujarat. A strong delegation from Gujarat represented the state in the Calcutta People's Health Assembly in Dec 2000. Six members represented Gujarat JSA in the Dhaka PHA. Unfortunately the Kutch earthquake in Jan 2001, followed by the post Godhra violence in Feb 2002, dissipated the collective spirit of Gujarat JSA. Members of the state JSA were active in their individual and organizational capacities in the relief and rehabilitation work following the earthquake and the Gujarat carnage. While health groups from outside Gujarat – eg. Medico Friends Circle - got involved in fact finding missions post the Godhra disturbances, Jan Swasthya Abhiyan, per se, was not active in these events. Some National JSA joint convenors tried to mobilise Gujarat JSA during 2001 but the priorities for the individual organizations were different.

It was only in 2004 around the activity of Public Hearings on the Denial of Right to Health Care that Gujarat JSA re-emerged as an organised entity. Members undertook assessments of CHCs and PHCs, Public Hearings were held in several districts - Dahod, where else?. Cases of denial of Right to Health Care were documented. A status paper on Health Services in Gujarat was prepared. Several organisations and individuals (??) went for the Western Region Public Hearing in Bhopal in July 2004. ??? Persons presented their testimonies. The Health Commissioner and Principal Secretary of Health were present and made a public apology.

The momentum of the campaign work around the Public Hearings was kept up by the preparatory processes of the 10<sup>th</sup> International Women's Health Meeting (IWHM). Many JSA members were/are also active in the Gujarat Women's Health movement.

In January 2005, a state level meeting for the 10<sup>th</sup> IWHM, on Health Rights Women's Lives: Challenges for Movement Building was hosted in Ahmedabad by CHETNA (the steering group comprised of ANANDI, CHETNA, and SAHAJ). The last session of this meeting was a dialogue with the state health officers.

The Health Commissioner invited the Civil Society groups to develop a Policy Paper outlining a partnership between the Government of Gujarat and civil society organizations. Thus began the next phase of Gujarat JSA in which women's organisations took a lead. Over a period of eight months (Feb 2005 – Sept 2005) a Policy for Interface between GOG Health Department and civil society groups was formulated. This consisted of a monitoring structure starting from the VHSC level to the State level with linked membership - VHSC to PHC to Block to District to State. The idea was that issues that did not get resolved at particular level e.g. the VHSC, would be taken to the next level i.e. the PHC, by representative members. Roles and responsibilities of the VHSC members were defined. A module for capacity building of the VHSC was also created. The GOG accepted this Policy



including the proposed structure. This structure and policy was then taken by JSA colleagues from other states, into the NRHM design processes which were underway at that time.

During 2005, following the process of drafting the above mentioned policy, Gujarat JSA members actively studied the Nagaland Communitisation Act and advocated that a study tour to Nagaland be undertaken for a team of government health officers and JSA members. At this time also JSA members realized that they needed to organize themselves to act at the District level to influence the District Health Societies. The District Health Societies under the RCH Programme had been constituted. JSA members studied the constitution and estimated that there were at least seven spaces that could be occupied by them. A systematic process of proposing organizations/individuals for each of these slots began as a District JSA activity. Some districts were somewhat successful - Baroda, Surendranagar, etc. This process continued through 2006. Through 2006 the JSA Secretariat anchored by Sejal Dand of ANANDI communicated with the NGO Coordinator (Gayatri Giri) in the RCH office in Gandhinagar to enrol or nominate MNGOs in the District Health Societies. In a state level JSA meeting in July 2006, an agenda item on the District Structure (District Health Mission, District Health Society, etc) informed the members of the spaces that they could occupy.

In 2006, JSA members were invited by the Health Department to participate in the meetings related to the Jansankhya Sthirta Kosh (JSK) and the 11<sup>th</sup> Five Year Plan. The document entitled 11<sup>th</sup> Five Year Plan – the Gujarat Health Sector Approach, included the following topics.

- Linkage of MDGS & National Goals with the state
- Priority issues & consideration
- Critical Analysis of Health and Family Welfare
- Investing for Health
- Partnership for Change

In 2006 JSA participated in the Gujarat Social Forum and organised several dialogues with other movements – Trade Unions – and networks. In fact, Gujarat has a rich collection of health related groups – Health Forum, GVHA, CommonHealth – several times with overlapping membership which can actually lead to convergence.

In March 2006, the seed of Gujarat Public Health Act (GPHA) was sown. During the period from Aug 2006 to July 2007, the JSA drafting group worked on six draft versions of the Gujarat PH Act. Four consultations were held by the Commissioner of Health and Secretary Family Welfare. Each draft was circulated widely for feedback. Feedback was invited from JSA members all over the country, legal experts like Mihir Desai, Public Health experts like Dr. S. Sridhar, Environment and Health activists like Rakhal Gaitonde, Nityanand, Madhumita. The draft PH Act was taken to the National Health Assembly II in Bhopal in 2007 where a panel of JSA friends from other states, Dr. Narendra Gupta, Manisha Gupte, Thelma Narayan provided valuable feedback on the draft Act.. (See Annexure-1 for details on the process of drafting the Gujarat PH Act).



In January 2007, the State JSA meeting in SEWA Rural worked on a concrete monitoring system of the Chiranjeevi Yojana by JSA members. The Health Department was claiming big achievements of the Chiranjeevi Yojana, but JSA members' ground level experiences were different. It was decided that we needed to come up with our counter view points of the Chiranjeevi Yojana. By February 2007, preparations for the National Health Assembly II began. Urban Health as an issue that the state JSA needed to focus on was also highlighted. A small state level consultation was organised by SAHAJ and Gujarat JSA.

<b>WHAT HAPPENED AT NHA-II? WHAT ISSUES DID GUJARAT REPRESENT THERE? WHO ALL WENT FROM GUJARAT?</b>
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By October 2008, the Government of Gujarat started approaching JSA to undertake the training of VHSCs. Training budgets were prepared. There was a lot of discussion within the JSA on the merits and elements of undertaking VHSC training as JSA. A compromise was struck - JSA would do this but the nodal agency would not be the JSA Secretariat but FRHS on behalf of JSA.

In mid 2009 the Secretariat of Gujarat JSA shifted from ANANDI to Deepak Foundation. During this year, issues like Food Security, Fortification of Atta, etc were discussed by JSA at the behest of the Anna Suraksha Abhiyan.

In 2010, Gujarat JSA concentrated on getting increasing membership and establishing regional level JSA groups. There was discussion on getting funding for specific project as JSA. Proposals were submitted but nothing materialised. In 2010, in a review organised by WADA NA TODO of achievement of gender related MDGs in Gujarat, JSA organised an effective panel where dalit and tribal women from different districts spoke about the discrimination that they faced vis a vis health care services.

One round of VHSC training by JSA members was over by early 2011. And the second round has begun. This has been the major learning for the Steering Committee members. In a meeting on July 24, 2011, Steering Committee members felt that there was no space for the organisations undertaking the VHSC training to collectively as JSA articulate their concerns, and advocate on the basis of this experience. They had been reduced to Project Implementers!

### **Issues Undertaken by Gujarat JSA**

Right to Health Care, Denial of Health Care Services (Monitoring services through CHCs, PHCs using guidelines for observation and survey on status of health services)

Drafting a Policy and Structure for civil society participation in monitoring health services

Drafting a State Public Health Act (along with members of national JSA and other health activists)

Organising to enter District Health Societies

Monitoring on Chiranjeevi Yojana and Quality of Care in Public Health Instructions

Occupational Health issues - Silicosis

Urban Health

### **Campaigns with other Movements**

Women's Right to Health Care

Gujarat Population Policy

Declining Sex Ratio and Sex Determination

Right to Food Security / Anna Suraksha

HPV Vaccines Pilot Project

Quality of Mental Health Care Services for Women

Access to Health Care of Marginalised Groups - Fish Workers, etc

### **Membership**

Number of members of Gujarat JSA-

### **Members involved consistently from the beginning**

ANANDI, AWAG, CHETNA, DEEPAK CHARITABLE TRUST, GRAM SEVA TRUST, SAHAJ, SEWA RURAL, SARTHI, PTRC

### **Steering Group-Present**

Deepak Foundation- Vadodara

CHETNA- Ahmedabad

IRDI-Surendranagar

UNNATI-Ahmedabad

P.T.R.C-Baroda

Sahaj Shishu Milap-Baroda

SEWA Rural-Jhagadia

ANANDI-Ahmedabad

SARTHI-Godhra Panchamahar

AWAG-Ahmedabad

Mahiti Gram Vikas Trust-Gholera





Sr No.	Organization/ Individual/ Ministry	Tally Marks	Total
1	ANANDI		8
2	A.R.E.R.C		1
3	AWAG		3
4	Bhanshali		1
5	BHASHA Research		2
6	Charutar Arogya Mandal		1
7	CHETNA		6
8	Deepak Charitable Trust		5
9	Devgadhi Mahila Sangathan		1
10	Dhruva Bayaf		1
11	Dr Amarjit Singh		1
12	Dr Duresh Patel		1
13	F.P.A.I		1
14	FRHS		4
15	Gayatri Giri		3
16	Gram Sewa Trust		5
17	Gram Vikas Trust		4
18	IRDI		5
19	Jagrut Mahila		1
20	Jashoda Narotam Trust		1
21	KMVS		4
22	Mahiti Gram Vikas Trust		3
23	Manav Kalyan Trust		3
24	Manoj Rajan		1
25	Navjivan Trust		3
26	Population Research Centre MSU		2
27	Prakash V Kotecha		1
28	PRAYAS		2
29	PRTC		3
30	PUCL-Vad Shanti Abhiyan		1
31	S. Srinivasan LOCOST		1
32	Saav		1
33	SAHAJ		11
34	SAHIYAR		2
35	Samarathan Trust		1
36	SARTHI		3
37	Sawa		1
38	SAWARAJ		2
39	SEWA		4
40	SEWA RURAL		6
41	Shroff Foundation		1
42	SWATI		1
43	Tribhuvandas Foundation		2
44	Unnati		1
45	WOHTRAC		3
46	Vedchi Pradesh Sewa Samiti		1
47	Yogini Khanolkar		1



48	Young Citizen	I	1
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### **Annexure- 1**

#### **Process of Drafting the Gujarat Public Health Act: JSA Perspective**

1. On 5-5-05, the PS Health and Family Welfare, S.R.Rao issued the National Human Rights Commission (NHRC) recommendation for National Action Plan to operationalize the Rights to Health Care in the department of Health and Family Welfare. As a response to this, the Health Commissioner attended the NHRC meeting on 4-3-06 and committed to doing a Public Health Act (PHA) in Gujarat. Thus on 4-3-06, the seed of Gujarat Public Health Act (GPHA) was sown.
2. Following the JSA-NHRC meeting at Delhi, Commissioner (Health) Secretary (Family Welfare) Gujarat, Dr. Amarjit Singh sent a draft of the Gujarat PH Act and a model PH Act of GOI (dated 1987) and Epidemic Disease Act (Rules and Orders, Sixth Edition, corrected up to Dec. 1952) to Renu and Dr. Pankaj Shah for comments and a request to finalize the Gujarat Draft Act in a time bound manner, so as to comply by the NHRC directives. At the same time, Sh. Amarjit Sinha from Ministry of Health Government of India contacted Abhay Shukla for JSA's input on a National Public Health Act within the NRHM framework.

3. Renu and Pankaj Shah had some discussion in Gujarat. With the purpose of formulation of the PHA in Gujarat, on 25-3-06 Dr Anant Phadke, Dr Abhay Shukla and Renu Khanna met at Pune for planning what JSA wanted in PHA to ensure Right to Health for all citizens. This meeting was to evolve a JSA response to both Gujarat Health Secretary as well as Government of India Health Department.

#### 4. Highlights of the Meeting

1. Abhay apprised Renu Khanna and Dr. Anant of the discussion that he has had with Jaya Sagde (a lawyer in Pune) and Shobhana Patil (a retired person with a PhD in Rights to Health). Together they had drafted a tentative structure for a Public Health Services Act. This structure was as follows:

*Title*

*Definition*

*Creation of Rights, who enjoyed these rights*

*Specific Rights*

*Choice of Treatment*

*Limited Agency: Children, elderly seriously ill, mentally affected Who can demand rights on their behalf*

*Remedy in case of Denial: situation for demand for redressal, actual remedy (compensation, reimbursement, punitive (?))*

*Non-discrimination*

*Informed consent*

*Other Ethical issues*

*Guaranteed services*

*Non provision of care*

*Inadequate QOC*

*Discriminatory insulting behavior 'dignity of personhood' bodily integrity'*

*Authorities*

*Authorities*

*Monitoring committee at block level*

*Tribunal at District Level: quasi judicial body*

*Epidemics/Outbreaks*

*Maintenance of records-Presentation to Assembly annually*

*Immunization*

*Compulsory and Mandatory-can people refuse?*

*Punishment (?)*

*Services*

*Community based for individuals e.g. Immunization*



*Community based for community: e.g. Water, epidemic*

*Facility based at various levels*

*Inter sectoral services:*

*Anganwadi*

*Nutrition Supplementation, Health check ups*

2. Dr. Abhay, Dr. Anant and Renu Khanna went through the Gujarat Public Health Act drafted in 2002 by Dr. Bhavsar (Dean of the Rajkot Medical College). They realized that this draft was based on the Model Public Health Act of GOI (1987).

Following was the feedback on the contents of that draft:

- The contents need to be made more contemporary
  - The notifiable diseases includes things like Typhus, cerebral-spinal fluid (meningitis) and not diseases like Malaria, TB, HIV-AIDS
  - Amongst the Social Determinants (Safe Water, Toilets etc.) Food needed to be included. Other Social Determinants also needed to be carefully looked at. With the Urban Renewal Mission being planned, Housing and Shelter section needs to be carefully drafted.
  - Occupational Health, Environment and Health (Health impact of Development Projects), Violence against women as a public health issue, Health needs in conflicts situation (gender issues within these), Disasters and Health (gender issues also), Migration and Health, HIV AIDS-STIs etc, Safe Sex Work were some other issues that needed to be included in a contemporary Public Health Act.
3. It was proposed that JSA should suggest for a 3 Part Public Health Act  
Part 1 an updated and modified version of the existing Public Health Act  
Part 2 Right to Health Services  
Part 3 Regulation of Private Health sector  
Putting together such an Act would be a major task. It would need inputs from at least three constituencies, (i) Faculty from PSM departments (for Part I contents) (ii) Lawyers with experience in Health Acts, and Right to Health Care (iii) JSA Representatives

A series of consultation would be required as well as we would have to commission someone (may be a couple of Lawyers) to draft such an act.

#### 4. Future Action

- (i) We should propose to Dr. Amarjit Singh  
Organize/ Host a consultation on this issue in May second half.  
Invitees: Prof Joga Rao (Bangalore Law College), Mihir Desai or Anand Grover  
Jaya Sagde, Meena Seshu (Patient's Rights), Pandey (ACASH worked on Breast Milk Act), Dr. Pandav (AIIMS), Dr. Bhavsar (PSM Dept.), Dr. Kotecha (PSM Dept), Dr. Kamakshi Bhate (PSM Dept)

## Gujarat Working Group

### JSA Members

The matters discussed during the meeting and the key issues to be included in the PHA of Gujarat were reported to Dr Amarjit Singh on 15-5-06.

5. On 19-6-06 the Health Commissioner and Secretary of Family Welfare developed a background note for a consultation on State Public Health Service Act. The consultation was to include lawyers, PSM professors, JSA members, Senior Government Health Officers. The first consultation on Gujarat PHA was held in Sola Ahmedabad on 23-8-06. Many experts and professionals both from within Gujarat and other parts of the country attended it.

A drafting group comprising of Dr Pankaj Shah, Dr Kamaxi Bhate (PSM Specialists), Dr Abhay Shuka (A Health Rights activist), Jaya Sagde (a Health Rights Lawyer), Gayatri Giri (State NGO Coordinator) and Renu Khanna (Gender and Health Rights activist) was set up. In October, Amita Pitre (from CEHAT who had developed the Maharashtra Private Clinical Establishment Regulation Legislation) was asked to help the Gujarat PH Act drafting process. She developed a draft on Registration & Quality Care in the private clinical establishment of Gujarat and added a new section in the overall draft of GPHA.

This group met several times over the next few months in Mumbai, Pune, Jhagadia, Vadodara to complete the first draft of the Act. A young legal intern working with Jaya Sagde Maitreyi anchored the entire process. The Health Commissioner arranged for all expenses to be covered. The drafting group volunteered their time and expertise for this task.

6. Over the period from Aug 2006 to July 2007, the JSA drafting group worked on six draft version of the Gujarat PH Act. Four consultations were held by the Commissioner of Health and Secretary Family Welfare. Each draft was circulated widely for feedback. Feedback was invited from JSA members all over the country, legal experts like Mihir Desai, Public Health experts like Dr. S. Sridhar, Environment and Health activists like Rakhal Gaitonde, Nityanand, Madhumita.

The draft PH Act was taken to the National Health Assembly II in Bhopal in 2007. A panel consisting of Dr. Thelma Narayan, Dr Narendra Gupta, Manisha Gupte and many others from the floor provided valuable inputs into the Act. The draft Act was sent to Mr. Padmanabha (Retired IAS officer, Karnataka who had worked on the Karnataka Health Task Force). His feedback was that the Act should be lean, and that the Rules should be detailed and specific (September-October 2007).

7. The Health Commissioner felt that the Draft act should undergo a final look-over before being tabled in the Assembly. He requested Dr Amar Jesani, Dr Thelma Narayan and Mr



Joga Rao (a Health Legislation expert from National Law School Bangalore) to do a final scrutiny.

8. Following this, a final draft at this stage was handed over to Mr Vasvada (Retired Legal secretary, GOG). The Health Commissioner's suggestion was that before the Draft Act be given to the Assembly, Mr Vasvada should vet it. The likelihood of its acceptance would be higher once he had vetted it.

On Dec 11, 2008, Mr Vasvada's draft was discussed in a state level meeting with the original drafting group. While making it acceptable as a legal document, the contents had been considerably weakened- the Act was decimated and reduced to a fragment of its original spirit and content. Subsequently the following were prepared by Mr. Vasvada:

- Public Health Rules (10-1-09)
- Gujarat PHA 2009 Statement of Objectives and Reasons (26-2-09)
- Draft for consultation only the Gujarat PHA (26-2-09)
- Salient features (no date)

9. Subsequently, two more meetings have been held by the Health Department on the Draft PH Act with very short notice. None of the original group has been able to attend the meeting.

## **List of Documents Referred**

### **A. Reference Material from Other Countries**

- Healthy People 2010 Understanding & Improving Health
- Comprehensive Health Care Programme for American Indians and Alaska Natives
- Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public
- The 'City Lab' User's Manual 2000 City of Milwaukee Public Health Laboratories
- Canada Health Act
- South African Health Act

### **B. Related Acts and Reference Material-Gujarat and National**

- Gujarat State Disaster Management Authority
- Rules and Orders made by the Government of Gujarat under Gujarat Act (Gujarat State Disaster Management Act, 2003)
- The Gujarat Municipalities Act 1993: A brief
- Turning Point Model State Public Health Act-Executive Summary
- Gujarat Emergency Medical Service Act 2006
- The Clinical Establishment Registration Act of 2006
- The Epidemic Disease Act, 1897
- Burial & Burning Ground
- Indian Public Health Standards (IPHS) Community Health Centers Level Draft Guideliness

### **C. Urban Health**

- Proposed Technical Assistance India: Support for the Jawaharlal Nehru National Urban Renewal Mission Project
- Guidelines for Projects of JNNURM on Urban Infrastructure and Governance

### **D. Preparatory Documents**

- NHRC Recommendation for a National Action Plan to Operationalize the Rights to Health Care
- Meeting with Dr. Anant Phadke, Dr. Abhay Shukla, Renu Khanna
- Act No III of 1897 An Act to Provide for the Better Prevention of the Spread of Dangerous Epidemic Disease
- Right to Health Care
- One Day Consultation on Gujarat State Public Health Services Act



## List of Documents Related to Gujarat Public Health Service Act

**NOTE:** Where ever there are two dates, the first date depicts the e-mail date and the second date depicts the event date.

Sr. No.	Date	Details	Involved person / organization	Notes
1	5-5-05	NHRC Recommendation for a National Action Plan to Operationalise the Rights to Health Care	Sent by SR Rao (PS Health & Family Welfare) addressed to Mrs Aruna Sharma	In response to this, the Health Commissioner attended a meeting NHRC on 4/3/2006 and committed to doing a PH Act for Gujarat.
2	6-3-06	Email from Dr. Amarjit Singh to Renu Khanna with an enclosed copy of model PHA and Epidemic Disease Act 1897	Sent by Dr Amarjit Singh to Renu Khanna	
3	25-3-06	Breif note on Meeting with Dr Anant Phadke, Dr Abhay Shukla and Renu Khanna <ul style="list-style-type: none"> <li>• Background</li> <li>• Highlights</li> </ul>	Dr Anant Phadke, Dr Abhay Shukla and Renu Khanna	Planning for what JSA wants in a PHA to ensure Right to Health for all citizens. Curves a history till date. <i>(use for write up)</i> The letter too gives important information on the history. <i>(Can be used)</i>
4	12-5-06	Email to Dr Amarjit Singh <ul style="list-style-type: none"> <li>• Feedback on content of draft GPHA by Renu Khanna and Dr. Pankaj</li> <li>• Matter discussed in the meeting of Dr Anant Phadke, Dr Abhay Shukla and Renu Khanna</li> </ul>	By Renu Khanna and Dr. Pankaj Shah	
5	19-6-06	Background Note for Consultation on State Public Health Service Act. <ul style="list-style-type: none"> <li>• What will be the key issues to be discussed?</li> <li>• Justification of PHA</li> </ul>	From Health (Commissioner) and Secretary (Family Welfare) office to lawyers, PSM professors, JSA members, Senior	<i>Useful document for history</i>

				govt health officers	
6	25-7-06		Email from Dr. Amarjit Singh for one day Consultation on Gujarat State Public Health Service Act (Aug 23, 2006) <ul style="list-style-type: none"> <li>List of invitees</li> <li>Key issues to be discussed in the consultation</li> <li>To send the background information of draft to Dr Amarjit Singh</li> </ul>	Sent by Dr Amarjit Singh to Renu Khanna and Dr Abhay Shukla	
7	23-8-06		1 <sup>st</sup> consultation on State PHA, Gujarat <ul style="list-style-type: none"> <li>List of invitees and participants</li> <li>Canada Health Act</li> </ul>	-	This was the first consultation
7a	?		Workshop on State PHA	-	For the first Consultation
7b	23-8-06		Schedule for the Consultation on State PHA, Gujarat <ul style="list-style-type: none"> <li>Schedule and outline</li> </ul>	-	
7c	23-8-06		Draft on Guj State PHA Par I (for discussion)	State Level Consultation, State Institute of Health and Family Welfare Sola, Ahmedabad	
7d	-	23-8-06	Consultation held in Sola Ahmedabad	-	
8	11-9-06	9-9-06	Minutes of the meeting held on 9-9-06 on JSA in DCT <ul style="list-style-type: none"> <li>Overview/ History of JSA</li> <li>PHA (2-3 lines)</li> <li>VHC</li> </ul>	Renu Khanna, Shruti Shroff, Jagdish Patel, Dr Sandhya (CORT)	
9	14-9-06	-	Mail to follow up and expedite the two letters sent to Kamaxi and Jaya. SWF letter to Kamaxi & Jaya thanking for participating in consultation held on 23-8-06 in Sola Ahmedabad	Sent by Dr. Amarjit Singh to Renu Khanna	
10	19-9-06	11&12-8-06	JSA members training minutes: <ul style="list-style-type: none"> <li>District Health Mission</li> <li>Dist Health Society</li> <li>Development of Working committee</li> </ul>	-	



			<ul style="list-style-type: none"> <li>• Janani Suraksha</li> <li>• Chiranjeevi Yojana</li> <li>• MMR &amp; IMR</li> </ul>		
11	Oct 2006		Amita's draft on Registration and Quality Care in the private clinical establishment of Gujarat	Amita Pitre	
12	13-10-06		Email to the JSA members <ul style="list-style-type: none"> <li>• Asking for comments on sections of drafts</li> </ul>	From Dr Abhay Shukla to JSA members	
13	?		Overall Structure of the Gujarat PHA (with responsibilities)	-	Draft-1 of GPHA
13a	?		Dr. Sridhar's comments on 1 <sup>st</sup> draft of GPHA	Dr Sridhar	
13b	?		Dr K Anands's comments on draft of GPHA	Dr K Anand	
13c	?		Dr Gayatri's comments on draft of GPHA	Dr Gayatri	
13d	?		General Comments on the draft of PHA	-	Draft-1 feedback
14	15-10-06	7-9-06	PHA drafting meeting in Mumbai	-	
15	15-10-06	-	Planning for 27 <sup>th</sup> JSA meeting Attached documents for JSA meeting <ul style="list-style-type: none"> <li>• Case study on MCH in tribal areas of Gujarat</li> <li>• VHC training</li> </ul>	From Sejal to Renu Khanna	
16	20-10-06	-	Corrected version of GPHA draft by Jaya on 18-10-06	Correction by Jaya and sent to Renu Khanna	
17	25-10-06	-	3rd Meeting of drafting group to Sola on 26- Draft on overall structure of GPHA (with responsibilities) Second draft of July 2002 (Edited by Kamaxi Bhate and Jaya)	E-mail from Renu Khanna to Dr Amarjit Singh	<i>(we have hard copies of both the documents probably)</i>
18	25-10-06		Second draft on Gujarat Public Health Act Government of Gujarat	Dr Kamaxi Bhate Dr Shirkala Acharya	This is a GOG draft done by BS Bhavsar and reviewed by Dr Kamaxi Bhate from the traditional PSM perspective. This was the first step

					to the JSA effort to draft a PH Act for Gujarat.
19	26-10-06	-	Reply to the e-mail of 25-10-06 <ul style="list-style-type: none"> <li>• Comments of Dr Mathur (UNICEF)</li> <li>• Nandraj's draft on regulation of private institution</li> <li>• Approach papers for 11<sup>th</sup> Plan</li> <li>• EMS Act</li> </ul>	E-mail from Dr. Amarjit Singh to Renu Khanna	
20	8-11-06	-	Proposal GPHA Proposal to prepare a draft of the GPHA, 2006	E-mail from Jaya to Dr Amarjit Singh	
21	2-12-06	-	Reply to urban health in PHA	E-mail from Pallavi to Renu Khanna	
22	5-12-06	-	Request to send information on special provision for reproductive health of women and girls	E-mail from Maitreyi to Renu Khanna	
23	11-12-06	-	Sridhar's and his colleague Joby's comments on GPHA draft	-	
24	11-12-06	-	Comments of Kamaxi Bhate and Shrikala Acharya on draft	E-mail from Kamaxi Bhate and Shrikala Acharya to Renu Khanna	
25	11-12-06	-	Some changes and queries on Special provision and urban health system by Maitrei	E-mail from Maitreyi to Renu Khanna	
26	11-12-06	-	Lorraine's changes on Kamaxi Bhate's draft	Lorraine to all members	
27	16-12-06	-	Updated version of PHA draft where draft was divided in 4 documents and comments by Maitreyi was also given.	Maitreyi to all members	
28	26-12-06	-	Highlights of Part II on PH conditions which may be move to Rules	Lorraine to Renu Khanna	
29	12-1-07		A Draft of State PHA (w/o Part IV) (Loose copy)	-	Draft-2
30	30-1-07		A Draft of State PHA (w/o Part IV) (Loose copy)	-	Draft-3
31	2-2-07		A Draft of State PHA (Spiral bound)	-	Draft-4
32	8-2-07	-	To finalize the bill to present in front of government	From Amar Jesani to Thelma Narayan	
33	9-2-07	-	Final 1 <sup>st</sup> draft of GPHA	To all members	



34	20-2-07	16-2-07	Comment and Correction made by Maitreyi after her meeting with Mihir	E-mail from Maitreyi to Renu Khanna	
35	20-2-07	-	Comments of Renu Khanna on Maitreyi and Mihir's comments ( <i>comments on the above comments</i> )	E-mail from Renu Khanna to Mihir and Maitreyi	
36	10-3-07	-	Some general and specific comments of Rakhal on GPHA draft	E-mail from Rakhal Gaitonde to Renu Khanna	
37	11-3-07		2 <sup>nd</sup> Consultation on PHA in Gujarat <ul style="list-style-type: none"> <li>Hard copy of the proposed draft was given to review and give their feedback</li> </ul>	To the members of JSA	
38	-	24-3-07	Meeting was held at Bhopal	-	
39	1-4-07	11-3-07	Consultation on GPHA was held at SIHFW	-	
40	8-4-07	-	The draft of GPHA should be finalized by the month end and should be submitted for necessary function	Dr. Gayatri to Renu Khanna	
41	12-5-07	-	Draft of GPHA after making the changes made after meeting in March (Ahmedabad) and May (Baroda)	Maitreyi to Renu Khanna	
42	12-5-07		3 <sup>rd</sup> Consultation on final draft PHA, Gujarat	Organized by Commissionerate of Health & Medical Service	Draft-5 ( <i>various corrections were done</i> )
43	21-5-07	-	Summary of GPHA draft by Maitreyi	Maitreyi to Renu Khanna	
44	22-5-07		Summary on the Gujarat PHA, 2006	Working Group JSA	
45	20-7-07		Email to finalize the proposed PHA of Gujarat under the chairmanship of the principal secretary Health & Family Welfare and discussion of 5 <sup>th</sup> Draft	Invitation to Renu Khanna from Dr Amarjit Singh for Consultation meeting	
46	27-7-07		Proposed Agenda for the 4 <sup>th</sup> consultation meeting on final draft of PHA <ul style="list-style-type: none"> <li>List of activities, participants and schedule of consultation</li> </ul>	-	
47	27-7-07		Feedback on PHA draft-5	-	

48	1-8-07		Draft of Gujarat PHA	-	Draft-6
49	7-8-07		Email on feedback of Dr Rajesh Gopal on PHA Gujarat	Dr Rajesh Gopal on Draft-5	
50	27-8-07		Notes on the draft of the proposed Gujarat PHA	P.Padmanabha	<i>Few corrections were made</i>
51	6-9-07	-	Some observations and comments of Padmanabha sent to Renu Khanna on draft of 27 Aug before our meeting	Sent by Padmanabha to Renu Khanna	
52	-	11-9-07	GPHA Final Draft-DRUGS (with corrections)	-	<i>(from PC)</i>
53	15-12-07	-	Maitrey's comments on GPHA draft	From Maitreyi to all members	
54	-	1-2-08	Draft on GPHA (with few corrections and highlights)	-	<i>(from PC)</i>
55	11-11-08	11-12-08	5 <sup>th</sup> Meeting was schedule on 11-12-08 at Gandhinagar	-	
56	-	10-1-09	Draft on Public Health Rules 2009 (all chapters are there)	-	<i>(from PC)</i>
57	-	10-1-09	Guj PHA 2009 Statements of Objectives and Reasons (with no corrections)	-	<i>(from PC)</i>
58	-	26-2-09	The GPHA 200 Statements and Objectives and Reasons	-	<i>(from PC)</i>
59	-	26-2-09	Draft for consultation only- The Gujarat PHA version dated 26-2-09	-	<i>(from PC)</i>
60	-	?	Salient features of reviewed draft	-	<i>(from PC)</i>



## Minutes of JSA Meeting at Jhagadia 26<sup>th</sup> and 27<sup>th</sup> Sept. 2011

(11a)

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**Venue:** Jhagadia SEWA Rural

**Date:** 26<sup>th</sup> and 27<sup>th</sup> Sept 2011

**Time:** 11 am – 5 pm Sept. 26, 2011, 9.30 am – 3 pm Sept 27, 2011.

### **Agenda of the meeting**

#### **26<sup>th</sup> Sept 2011**

- VHSC learning and evaluation

#### **27<sup>th</sup> Sept. 2011**

- History of National and Gujarat JSA
- Review of Gujarat JSA
- Health Issues to be taken by Guj JSA in coming year
- Organizational Issues and Future Action of JSA
- To decide who will represent Gujarat JSA in National JSA meeting in Nagpur on 10-12<sup>th</sup> Nov. 2011

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### **Minutes of 26<sup>th</sup> Sept. 2011**

**Time:** 11 am – 5 pm

#### **Members Present (See Annexure 1 a)**

Dr Pankaj Shah formally welcomed everyone. A quick round of introduction was carried out. Dr Pankaj Shah asked Surendrabhai (FRHS) to share with those present the highlights and main findings of VHSC Phase-I evaluation.

Surendrabhai talked on the **History, Highlights of the Evaluation and Future Actions in 2<sup>nd</sup> Phase of VHSC**

#### **Brief History of VHSC**

- Government introduced the concept of VHSC which was implemented by the JSA. In the first phase 3500 VHSCs from the state were trained.
- A baseline study was carried out based on which the JSA organizational members involved in VHSC training decided on which topics training should be given, how should be given.
- There was a half day orientation meeting in the villages. The training period was of 3 days, 2 days were the training days at PHC and the 3<sup>rd</sup> was the refreshing training. The training was very fruitful. After seeing the positive result of phase-I VHSC training, government added 2500 VHSC in phase-II.
- In order to learn from Phase-I VHSC training, 50 trained and 50 untrained VHSCs were studied. A total of 550 responses were received. 35 VHSCs also gave their

feedback. The evaluation report will be released soon and a video film on VHSC will be developed by CHETNA.

### **Highlights of the Evaluation**

- Fifty percent of the villages didn't have knowledge on VHSC details. They didn't even know about the existence of their VHSCs. Recording system of the VHSC was poor, like maintenance of accounts, vouchers, etc.
- Difficulties faced during the VHSC training were absenteeism of health personnel like ANM, AWW, ASHA, etc in training, presence of different people on three days of training, drop outs of trainees in the 3 days training session.
- Based on these findings it was decided that instead of 3 days' training, VHSC training will be conducted for 2 days. Four follow up review meetings in a year will be organized.
- VHSC were trained on: how to structure meeting agenda, how to write minutes of the meeting and how to inform all the members of VHSC. VHSC were trained in designing the Future Action Plan also.
- It was observed that the health services are available to people of the villages and they have also started utilizing them.
- The second phase Training of Trainers has started.
- 25 to 30% VHSCs have regular meetings. There is involvement in Mamta Divas, Cleanliness campaigns in villages. Action Plans are being made by a few VHSCs.

### **Future Actions in 2<sup>nd</sup> Phase of VHSC training**

- Situational analysis of the VHSC in the village should be done. The baseline Survey forms have been simplified.
- There is need to develop a system through which feedback on the training carried out can be obtained. Mentoring will be done through a SMS based system which is under process of development.
- Mentoring of Phase-I VHSCs will be done by NGOs without any financial support from GOG.
- A list of new government policies and schemes has been included in the VHSC training module.
- Phase-II also has a provision for exposure/ exchange visits to NGO field area.
- MOU with each organization is prepared.
- The evaluation of Phase-I VHSC training will be circulated to all the JSA organization members.

Dr Shrey who was chairing this session, summarized the issues as told by Surendrabhai. He asked the members involved in the VHSC training to give their feedback on VHSC Phase-I training. Various points mentioned by the members are given below.



1. VHSC evaluation report should be circulated to the JSA members and after getting their feedback, it should be submitted to the government.
2. Radical change or improvement in the health indicators can't be expected from the VHSC training, as it is a long term process involving behavior change process.
3. In 1<sup>st</sup> phase we can assess the process indicators like no. of meetings organized, no. of issues raised by people, no of issues solved by the VHSC, etc
4. VHSC members are now capable of identifying the people/ department/ groups to be contacted for village problems like electricity supply, drinking water, roads, hand pumps, etc
5. It is too early for the VHSC members to have the confidence to do community monitoring. There is fear of backlash from the system.
6. Block Health Officers and the PHC staff should be involved in the VHSC meetings and trainings and the training should not be carried out in PHC because the PHC staffs are busy in their own work.  
*To this Surendrabhai told that it is not compulsory to carry out the VHSC meetings or training in PHC. It can be carried out in any village hall, etc.*
7. Villages with different population are given same amount of untied fund i.e. Rs 10,000, which is not appropriate.
8. NGO selection should be better- some NGOs have not delivered results till the end of the year.
9. It has been observed that community people are ready to meet for VHSC meetings but ANM or AWW, etc don't turn up and thus meeting fails. For that reason FRHS should write a letter to government for making presence of AWW, ANM, ASHA, etc mandatory in the VHSC meetings.
10. There should be only one committee for Sanitation instead of many committees in the village which end ups in confusion. GR for this should be made.
11. The VHSCs have utilized 65% of the untied funds for health prizes.
12. Guidelines on fund utilization should be developed. The guidelines should be suggested by the people and not by the government. So the Untied fund of Rs. 10,000 should be used for the needs of the people in that village and not as decided by the district or government authorities.
13. In order to see effective result in the chain from VHSC-PHC-Block-Taluka-District-State at least 5 years are required. So the period of VHSC project should be lengthened. VHSC should have convergence with Gram Sabha / Gram Panchayat.
14. NRHM emphasized the formation of VHSCs from the framework of decentralization and promoting accountability. The Central Government pilot programme on Community Monitoring was based on these principles.



Government of Gujarat programme should also incorporate the principles of accountability and community monitoring in the VHSC training.

15. NRHM is going to end in 2012 and planning for 12<sup>th</sup> Five Year Plan has started. In the working group on JSA members at the national level have recommended Review of NRHM set up by the Planning Commission increase in the investment for community monitoring.. Gujarat JSA should similarly propose increased investment for the VHSC training.
16. Government should provide funds for mentoring and orientation of the VHSC Phase-I. Evidence for requirement of mentoring should be collected. Inadequate support for continuing the mentoring will result as a waste of money because results will be very limited.
17. NGOS present shared that Block level Jan Samwads were very important- they registered the VHSC members .More efforts should be given to build capacity for effective Jan Samwad.
18. JSA should ask for more people's participation in the GR. For sustainability VHSCs should have more people's representatives than the government workers. Investment in people's representatives will be more sustainable.
19. Funds required to find out how much of the Village Health Action Plans have been implemented.
20. Many of the NGOs are not Health NGOs- their community level staff also need Health training before they can train VHSCs to carry out their role of Community Action for Health.

### How to make VHSC second phase more productive?

Suggestions and experiences of member organizations were tabulated to make the second phase of VHSC training more effective and productive.

Two days training instruction	Mentoring instruction	Other instruction
<ul style="list-style-type: none"> <li>• Usage of high technology like LCDs in training</li> <li>• Travelling allowances should be given at the end of two days training</li> <li>• Night stay arrangements and some events should be arranged in overnight trainings</li> <li>• Training through Group Discussion and Participatory methods.</li> <li>• Equality among the trainers and trainees- everyone</li> </ul>	<ul style="list-style-type: none"> <li>• Frequent visits to villages through link workers, health workers, etc</li> <li>• Mahila Mandal meetings</li> <li>• Involvement of Panchayat members and other powerful members in the VHSCs</li> <li>• Optimistic and positive thinking and attitude- Build on the achievements and strengths</li> <li>• Meaning of Mentoring</li> <li>'We are with you'</li> <li>'Your questions are valid'</li> </ul>	<ul style="list-style-type: none"> <li>• Jan Samwad</li> <li>• Advocacy required for               <ul style="list-style-type: none"> <li>▪ Fund for mentoring</li> <li>▪ Fund for Orientation</li> <li>▪ Contracts for 2 years</li> </ul> </li> </ul>



should sit at the same level. • Gujarat JSA member organization should share their training resources for the VHSC training. (Annexure A) • Organizing events like Health Padhyatra through villages. • Involving VHSC members in all campaigns/events.	• Mini Taleem in PHCs	
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### Decisions Taken

Based on the detailed review by the JSA members, it was decided that two letters will be written by Gujarat JSA secretariat, one will be sent to FRHS and other to GOG. The letter to FRHS would be aimed at strengthening communication between JSA Secretariat, member organization and FRHS. The letter to Government of Gujarat would be to communicate suggestions for Phase-II (See Annexure 2 for the letters)

### Other Decisions

- When the MOUs (Organization- FRHS and FRHS-GOG) have been circulated to all the members, members can give their feedback and that will be worked upon by the JSA SC members.
-

## **Minutes of 27<sup>th</sup> Sept. 2011**

**Time:** 9.30 am – 3 pm

### **Members Present (See Annexure 1b)**

Dr Pankaj Shah chaired the meeting by listing the agenda for the day meeting. He shared his experience on 26<sup>th</sup> Sept 2011 meeting of Bharuch District Health Officers related to the ASHA Resource Center. In the meeting it was told that an ASHA Resource Center will be established at Taluka, District and one at State level. The Center will be responsible for trainings for strengthening an ASHA. There is space for one JSA members in the Committees/ ASHA Mentoring Group at the District and State levels. For that Dr. Harshaben's organization will represent JSA in ASHA Resource Center as they are an existing member of ASHA Resource Center and now will represent Gujarat JSA too.

### **Presentation of 2 letters drafted on evaluation of 26<sup>th</sup> Sept 2011 meeting**

Two letters were drafted by a sub committee consisting of Dr Shrey Desai, Pradipa, Dr Harsha, Suhag on basis of the feedback and suggestions obtained on the previous day meeting on VHSC evaluation and learning. One letter was drafted to the FRHS from the JSA Secretariat and another to the Government of Gujarat from JSA Secretariat. Letters were presented from to the house and modifications were made. Finalized letters are in Annexure -3

### **Agenda on: History of National and Gujarat JSA**

- Renu Khanna gave a brief introduction on the purpose of presenting history of national and state JSA. She asked the members to contribute and add to the history of Gujarat JSA.
- Neeta Hardikar presented the Powerpoint on both histories.

### Contribution of the JSA members in the Gujarat JSA History



- Jagdishbhai added the event of World Health Assembly held at Bangladesh in 2000. Six members from Gujarat attended the event. A post Gujarat JSA meeting was supposed to be organized for sharing the experience and learning of World Assembly, but due to earthquake it didn't happen.
- Two review meetings were held. NHRC was sensitized about the Gujarat health problems like Silicosis. A National Task Force on Silicosis was constituted by the NHRC.
- There are 55 members in Gujarat JSA, 12 Steering Committee members.
- Gujarat Govt. invited JSA for meetings on the School Health Programme and the Public Health Act. The Secretariat represented the JSA.
- Dr. Harshaben said that their organization would have the documents of the PHA 1 at Dhaka - The Gujarat People's Health Charter etc.

### Review of Gujarat JSA

The members were asked to write down the answers to the questions below and share with the larger group.

1. *Enlist the Strength, Weakness, Opportunities and Threats of GJSA*
2. *What does GJSA mean to the members?*

Feedbacks of the members are given below collectively.

#### Strengths

- JSA can bring a change in the policy. It represents group strength, a collective voice.
- It acts as a watch dog and a pressure creator at the district level.
- JSA spreads awareness among the members which becomes the basis for rajuat and demands from the people.
- It is a forum for new organizations to get empowered and learn about health rights.
- Members from different field and expertise are present in the JSA. Diversity is strength.
- Strong pro people approach. Members work with people's organizations/CBOs.
- Lessons and learning from different districts through the JSA members helps in strengthening the members and JSA as a whole.
- Collective strength and analysis eg the VHSC training issue. The liason with the government can be good.
- Get strength from JSA to intervene in people's issues - Through JSA area wise problems are solved.
- Development of individuals and organizations – perspective development. Forum for exchange of learning among members.
- JSA runs without funds. It stands on the contribution and willingness of the JSA members.
- JSA works on Women's Health issues.
- Good image of JSA – Govt. is forced (?) to ask JSA for opinion on policy matters eg VHSC, PH Act.

#### Weakness



- Lack of coordination, consistency and communication among the JSA members.
- Lack of publications by the Gujarat JSA
- Because of lack of coordination among the members, no collective decision is taken and thus no recommendations are being given to the government.
- No continuity in membership – sometimes one person attends from an organization, the next time a different person.
- We don't have a strong presence in each every district in Gujarat.
- Organizations have internal conflicts – on the one hand as members of JSA they voice and stand for rights based actions. On the other hand they have a relationship of dependence/ collaboration/partnership with the government.
- Not clarified vision, norms etc. While registering the members for JSA membership.
- We have not refined our critiques of policies and programmes. We do not write or publish our collective positions enough.
- We do not respond fast enough, we do not have focused campaigns. We have not communicated our positions to the public.
- As the JSA undertook the government project of VHSC, no suggestions or recommendations can be given to the government.
- Because of project implementation mode, we have lost sight of the original vision and mission of JSA.
- All organizations do not agree on issues, we do not meet often enough to develop common positions. Therefore there is a lack of strong statements or actions.
- We have not undertaken common activities for campaigns at the village level.
- People's own perspective is not one of right to health - it is a struggle to change this (Threat??)
- Number of people who attend these meetings is less.

### Opportunities

- Higher enrollment of organization in JSA and increased orientation of JSA.
- Need of e-forum for JSA, opportunity for increased networking through internet, social networking media.
- Coordination with other networks and health groups for Networking, Advocacy and Awareness
- Need to increase membership to make voice stronger. We have a credible identity.
- Time is ripe for review of Gujarat Health Charter
- Various organization visits should be done – we should meet in different organizations, learn from them, support them.
- Sharing of the resource materials developed by different member organizations
- Government says that it wants to improve health outcomes and indicators. We can combine our vision with government aims and meet government at one common point of improving health indicators.
- More of Campaign oriented
- Panchayat elections are coming up – we can use the Gujarat People's Health Charter to mobilize people and make right to health into a political issue.
- Community monitoring and Gujarat Public Trust

### Threats

- We have not been able to educate even our friends on health rights issues – eg. The meaning of the Public Health Act.



- The Gujarat Public Trust Act will be very restrictive for NGOs. Maybe we should organize ourselves around this?
- People in the Government don't recognize the suggestions or recommendations made by the JSA
- Lack of monitoring of the private health services – Chiranjeevi doctors
- Opposition from government health officials towards the organization. Development of enmity.
- Development of anti-civil society stance among State and towards JSA. This will influence organizations; decisions about taking up responsibility of the Secretariat.
- New members have financial expectations – eg projects and are in the mode of chasing project outputs and outcomes.
- What will we do with this SWOT Analysis? Will it lead to us taking up a couple of important campaigns and pursuing them?

#### What does GJSA means to the members?

- We have done good work together in the past – we should continue it.
- Solidarity on health issues and agendas.
- Gujarat is a state of stark inequities – in JSA we should rally around strength to challenge these.
- It's a forum to represent people's health needs in front of Government of Gujarat.
- Advocacy is the main role of the JSA
- It should not undertake the work of implementation of government projects
- It is a policy change maker platform
- It is a strengthening tool for both the organizations and the JSA.

We need to educate the government at different levels about the collective strength of Gujarat JSA.

We should some criteria of making new members, not allow persons with party affiliations to get into JSA.

#### **Focus Areas for future work**

A list of health issues was developed by the JSA SC on 24<sup>th</sup> Aug. 2011 in a meeting at SAHAJ (Baroda). It was decided in the meeting that prioritizing of the issues will be done by the JSA members and based on that, issues to be taken up by the JSA in coming year will be decided. For that reason, the list of issues was presented among the members in this meeting of Jhagadia.

Members were asked to point out the issues which their organization is currently working. Tally marking of the issues was done. Two issues were added to the list (1) Health Statistics and (2) Health of Disabled. Results of the tally marking of the issues on basis of the number of present member organizations working on the issues are given below.

It was decided that this list would be taken up in the next meeting for concrete planning of future campaigns by Gujarat JSA.

Health Issues	No. of present organization
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	working on the issue
Child Nutrition	4
Drinking Water and Cleanliness	4
Anna Suraksha	2
Violence on Women	2
Beti Bachao	0
Maternal and Child Health	6
Government Services	3
Private Sector Monitoring	2
Urban Health	2
Occupational Health	1
Migrant Health and Nutrition	1
Tobacco and life style disorder	2
Community Monitoring	6
Health Statistics	2
Health of Disabled	3

#### Announcement by Jadish Patel

- Jagdishbhai asked the JSA to write a letter to the Government of Gujarat in order to pay compensation as directed by the Supreme Court of Rs 3 lacs to the silicosis patients who died in Gujarat. Total number of the government recognized silicosis patient in Gujarat are 293. Government was supposed to pay Rs 3 lacs each to 293 patients, which has not been done. So to insist government for this, Gujarat JSA should write a letter to GOG.
- He also asked JSA to write a letter to GOG to modify Factory Act.
- Meeting of Asian Victim Rights will be organized in Jaipur in November 2011. One member of Gujarat JSA should attend this meeting.

#### Decisions Taken

- Jagdishbhai will mail draft on Occupational Health and Factory Act to the JSA Secretariat.
- PTRC will undertake training on Leptospirosis in Navsari District.
- Nagpur JSA meeting – Secretariat will ask Steering Committee members who can represent Gujarat – Sejal from AWAG, Pradipa from ANANDI, Viren bhai TBF, Nirmalben/Harish from SARTHI, someone from CHETNA, Vijeta and Sunanada from SAHAJ.
- We need to develop a JSA perspective on the ASHA Worker.
- List of issues will be mailed to the JSA members again to prioritize.
- List of questions on Gujarat JSA will also be mailed and feedback of the members will be obtained at the earliest.



- Subcommittee for eth VHSC issue – Shrey Desai, Pallavi, Pradeepa, Renu, Secretariat.

Next SC Meeting on Nov. 20, 2011.

Meeting ended with a sincere vote of thanks to SEWA Rural for hosting the meeting.

**Annexure-1a:** List of Members present in the Meeting (26<sup>th</sup> Sept 2011)

1. SEWA Rural Jhagadia- Dr Pankaj Shah, Dr. Dhiren Modi, Dr. Shrey Desai, Kantibhai Parmar, Nileshbhai, Jyotsana Rohit and Ghanshyam Patel
2. FRHS- Surendrabhai Shah
3. Anjali (Ranasan)- Anitaben Shah and Alkaben Thakkar
4. SWATI (Surnedranagar) – Padmaben
5. Deepak Charitable Trust- Nandini Srivastava and Suhag Jani
6. GVHA- Gita Rawal and Jashubhai
7. Manav Kalyan Trust- Rathod Sureshbhai, Dabi Vimabhai and Rathod Suresh Vimalbhai
8. SAVA (Jamnagar)- Kotecha Ketan
9. Cohesion Foundation Trust- Hasmukh Patel, Bhavesh Dhansi, Pankaj Shrimukh
10. Gramya Vikas Trust- Jhoshanaben, Jadeja Jydsmerba
11. SAHAJ- Renu Khanna and Vijeta Jain
12. ANANDI- Neeta Hardikar and Pradeepa
13. Naisargik Trust Palanpur- Patel Swapnil
14. Gram Seva Trust, Kharel- Dr Harsha Shah
15. Sambandh- Chohiya Lata
16. SARTHI, Godhra- Harishbhai Patel
17. PTRC- Jagdish Patel

**Annexure 1b: Members present on Sept 27, 2011**

18. SEWA Rural Jhagadia- Dr Pankaj Shah, Dr. Dhiren Modi, Dr. Shrey Desai, Kantibhai Parmar, Nileshbhai, Jyotsana Rohit and Ghanshyam Patel
19. Anjali (Ranasan)- Anitaben Shah and Alkaben Thakkar
20. SWATI (Surnedranagar) – Padmaben
21. Deepak Charitable Trust- Suhag Jani
22. Manav Kalyan Trust- Rathod Surendrabhai, Dabi Vimabhai and Rathod Suresh Vimalbhai
23. SAVA (Jamnagar)- Kotecha Ketan
24. Cohesion Foundation Trust- Hasmukh Patel, Bhavesh Dhansi, Pankaj Shrimukh
25. Gramya Vikas Trust- Jhoshanaben, Jadeja Jydsmerba
26. SAHAJ- Renu Khanna and Vijeta Jain
27. ANANDI- Neeta Hardikar and Pradeepa
28. Naisargik Trust Palanpur- Patel Swapnil
29. Gram Seva Trust, Kharel- Dr Harsha Shah



- 30. Sambandh- Chohiya Lata
- 31. SARTHI, Godhra- Harishbhai Patel
- 32. PTRC- Jagdish Patel

**Annexure-2:** Material Produced by Member Organizations

- 1. 'Toilets: Difference in our Lives' by Gram Seva Trust, Kharel

**Annexure -3** Draft Letters 09819854296

(i) Letter to FRHS

Date: 26/9/11

Subject: JSA meeting

Dear Nirmalaben,

As you know, JSA general body meeting took place at SEWA Rural, Jhagadia on 26/9/11. Representatives from 17 member organizations were present - list of those who attended is attached with this letter. A major agenda was the review of the first phase of the VHSC training and planning for the second phase of training. All JSA member organizations present resolved to sincerely thank FRHS for its contribution as the nodal agency for the VHSC training programme. Thank you also for being open to all suggestions during first phase implementation and evaluation.

We were informed by Mr. Shah that the MOU for the second phase has already been signed by FRHS. We have yet to see the MOU – he said that he would send it to us. We were wondering how the MOU could be signed without considering the evaluation of Phase 1? Is it still a draft MOU? We hope that it is. If not, we will need to negotiate with the government for some amendments.

Another point which emerged from our discussions was that most NGOs are reluctant to voice their disagreements in front of government representatives. For this it appears that meetings of implementing NGOs should be conducted without government representatives present. July 1 meeting at IIM was cited by many NGOs as one where there was no space to discuss and disagree.

The review with those present elicited several lessons learnt which we are attaching in the annexure. These Lessons Learnt should be incorporated in Phase 2. We can discuss these during our meeting.

The JSA member organizations felt that we could further improve communication between FRHS and JSA member organizations. Following are some of the suggestions regarding such communication.

- (1) It is desirable that FRHS communicates with other member organizations whenever the government seeks JSA's opinion about issue related to the VHSC programme.
- (2) At least 3 members of steering committee should be present when FRHS meets with the government representatives to discuss important matters related to VHSC programme.
- (3) The members present in the meeting also stated that they on their part, should respond to all communication sent by FRHS at the earliest.
- (4) Please circulate a draft copy of MOU of second phase to the JSA secretariat and all member organization at the earliest. JSA secretariat would like to review and offer modifications to be made to the new MOU. (Mr. Shah has circulated it since – we are waiting for the Steering Committee's feedback on this.)
- (5) JSA is sure that conclusions of formal evaluation would be added to the new MOU. Additionally, JSA requests FRHS to base the Phase 2 MOU on the "lessons learned".
- (6) Please include salient features of discussion about the "Lessons learned" into the formal evaluation report being prepared.
- (7) JSA suggests that the Steering Committee and FRHS meet and finalize/amend the phase 2 MOU.

JSA is planning to send the attached letter to the government regarding Phase 2 MOU.

The JSA member organizations feel that implementing above suggestions would improve the operations and implementation of Phase 2.

Thanking you once again,

Yours truly,

JSA secretariat

(ii) Letter to Government of Gujarat

Date. 26/09/11



To, MD NRHM/ health commissioner  
Subject: JSA meeting

A JSA general body meeting took place at SEWA Rural, Jhagadia on 26/9/11. Representatives from 17 member organizations were present (list attached). A major agenda was the review of Phase 1 of VHSC training and planning for Phase 2.

Following are issues of agreement among the member organizations present.

- (1) Members felt that ongoing support for the fledgling VHSCs is important; otherwise they will die a gradual death. Experience of the implementing NGOs shows that VHSCs need capacity building not only in skills to carry out their role and responsibilities but also to increase their knowledge and understanding of health issues of the community. Mentoring of almost 3500 VHSC trained during first phase is essential. Funds should be provided by the government to mentor previously trained VHSCs for 2 further years.
- (2) There has been some discussion on mentoring of the VHSC trained in phase 1. Members felt that FRHS as nodal agency and representatives of the steering group of JSA could discuss content of mentoring process and budget for the same. This would help take timely decision for the Phase 2 of which the discussions are underway.
- (3) Proposed duration of contract for second phase of training and mentoring is 1 year at present which JSA members feel is inadequate. Review of contracts each year lead to uncertainty, disruption in the work. We propose at least 3 years of contract period including the mentoring for two years after the first year of training . This would ensure follow up and action on the village health plans that would be made part of VHSC training.
- (4) Phase 2 should provide funds for orientation meetings at village level for every VHSC before formal training begins.
- (5) Lessons learned from evaluation (attached with this letter) should be incorporated during the next phase. One important lesson is that Block Level Jan Samwads act as an energiser/booster for the trained VHSCs. They also provide the continuity – going beyond the village level to higher levels for problems that cannot be solved at the village level. Another lesson learnt is that Padyatras through villages are a way of involving VHSC members and increasing their accountability for solving health problems in the villages. Promising practices like these should be compiled and included in the training of VHSCs.
- (6) There should be provision of funds for block level meeting/jan-samvad.

JSA member organizations look forward to an opportunity to discuss these suggestions with the Health Commissioner and the MD in the collective endeavour to ensure that VHSC training project is successful in the coming years.

JSA requests a meeting with you to discuss above issues further.

Yours truly,

JSA secretariat



## Chhattisgarh Jan Swasthya Abhiyan State level meeting 8<sup>th</sup> November, Raipur

The state level meeting of Jan Swasthya Abhiyan, Chhattisgarh was held in Raipur on 8<sup>th</sup> November 2011. The meeting aimed to discuss the issues and challenges in attaining the right to health and healthcare in Chhattisgarh and plan to address these issues. A total of 36 individuals participated in the meeting from around 21 organizations from different parts of the state.

The objectives of the meeting were as follows:

- • Introduction about JSA especially to the new participants in the meeting to make them aware about the kind of network and the work JSA is involved with
- • To share the experience of those members who have already been associated with JSA and discuss the PANS process
- • To decide on how to take this movement forward and identifying specific health issues to work on

Firstly, Sulakshana Nandi, state convener, shared about JSA Chhattisgarh. This was supplemented by Dr. Jena of Shaheed Hospital and Shalini. Sant from JSS shared how JSA functions in Maharashtra and MP. After that, PANS was discussed. Then future action plan was chalked out.

### Observations from the PANS process

JSA in Chhattisgarh started in 2004 addressing the cases of denial to healthcare when not many organizations were working on health or aware about such a movement. Since then various participating organizations have been actively involved in the Peoples Rural health watch and the Health Assembly at Bhopal. But meetings have not been regular at the state level. Also, the organizations, except for a few, are not involved with JSA in a sustained manner. A need was felt for the various organizations to give a commitment for participation in JSA.

The importance of regular JSA meetings was emphasized and it was suggested that the meetings be held on a rotation basis with different organizations taking responsibility each time. It was discussed that due to the lack of proper organisational structure in JSA Chhattisgarh, it becomes the responsibility of certain individuals or the organization who are voluntarily involved with the movement. Thus, it is necessary to have a proper structure for JSA and an action plan to get things on track.

A lot of work on health rights is being done by various grassroots and other organizations but it is necessary to bring all these efforts together on a common platform so that various issues could be brought to notice of the government. Now, as the network seems to be expanding it's necessary to also build the capacities of the people involved in order to get the desired results. Along with this, the work done by the various organizations on health rights should be shared regularly so as to see in which direction the health movement is headed. Advocacy efforts as JSA need to be undertaken in the state.

## Issues to be addressed in future

During the discussion, various issues related to the right to health and healthcare were discussed, most prominently, maternal health, maternal mortality and the recently introduced insurance scheme Rashtriya Swasthya Bima Yojna (RSBY).

Major issues of concern

- • Need for free services to be provided at facilities
- • High out of pocket expenditure
- • Issues with Quality of services provided for institutional deliveries
- • Availability and quality of services at the DH/CHC/ PHC
- • Use of RTI to improve health services-(case study was presented on use of RTI in improving JSY)
- • Quality of Ante natal check up
- • Family planning and contraception
- • Complications after delivery: to what extent are they addressed?
- • Maternal death audits
- • Recognition of Mitanins for the work they do
- • Non-Availability of medicines and the other things required during pregnancy and at the time of delivery
- • Health seeking behavior even in tribal areas now towards health facilities
- • Inclusion of poor families in BPL
- • Lack of awareness among the people about RSBY
- • Low enrollment rate and low utilization rate under RSBY
- • Exclusion of PTGs who are not part of BPL list but have Antyodaya cards
- • Experiences of denial of treatment under RSBY
- • Technical problems (computer is not functional, no match found for the finger prints or unclear photograph) due to which BPL families fail to make use of the smart card
- • Cumbersome procedure involved in RSBY (enrollment, availing treatment at the hospitals, internet inaccessibility in remote areas) resulting in low utilisation
- • Need to include OPD under RSBY
- • Empanellement of hospitals under RSBY- problems with certain private hospitals



- 
- • Sensitisation of hospital staff necessary
- 

## Immediate action plan

### 1. 1. Formation of committee

For immediate start of the work, a temporary committee was formed involving voluntary participation of the organizations. The following organizations came forward to start the work:

Name of the organization

1. - Sajak, Mahasamund
2. -Lok Shakti Samiti, Raigarh
3. -Jan Swasthya Sahyog, Bilaspur
4. -Chhattisgarh Gramin Vikas Aiwam Kalyan Samaj Sewi Sanstha, Mahasamund
5. -Gandhi Gram Vikas Samiti, Bilaspur
6. -Chhattisgarh Gramin Sewa Samiti, Mahasamund
7. -Right to Food Campaign, Chhattisgarh
8. -Chaupal
9. -Jan Jagran Samiti, Janjgir Champa
10. -Shaheed Hospital
11. -Jan Jagriti Manch, Raipur
12. -Chhattisgarh Viklang Manch
13. -Shalini Raman
14. -Aastha Samiti, Kawardha
15. -Mitwaa Mahila Kalyan Aiwam Sewa Samiti, Bilaspur
16. -Sehbhagi Samaj Sewi Sanstha, Kanker
17. -Public Health Resource Network, Raipur

### 2. 2. Issues to be addressed

Amongst all the issues discussed, RSBY was unanimously selected as the most crucial issue to work on at this point of time. In the coming few months, it was decided that the members would conduct a survey in their respective field areas to assess the number of BPL families enrolled under RSBY, out of them how many have utilized the scheme so far and to find out how was their experience.

The survey would be done at the village level as well as the household level. For the survey, two formats would be prepared and circulated to all the members by 16<sup>th</sup> November.

Along with RSBY, attempts will be made to contact the people or the families affected in Balod and Kawardha where many people lost their eye sight after cataract operation.

### 3. 3. Next meeting

The next JSA meeting is scheduled on 7<sup>th</sup> January, 2011 in which the data from the RSBY survey will be shared. Along with that further planning would be done, including formation of a formal state level JSA committee and selection of district level representatives.

4 The minutes of the current meeting will be posted to all participants. For future correspondence, sms and post will be used as most of the organizations do not use email.

### List of participants:

S No	Name of the Participant	Name of the Organisation	District
1	Chandrakant	Astha Samiti	Kawardha
2	Shyamanand Barik	Chhattisgarh Gramin Vikas Evam Kalyan Samaj Sevi Santha	Mahasamund
3	Jangliram Markam	Jan Jati Vikas Samiti	Sarguja
4	Ganeshwari Tirky	Jan Jati Vikas Samiti	Sarguja
5	Kalindi Sahu	Gandhi Gram Vikas Samiti,	Bilaspur
6	Sohadra Vatti	Sahbhagi Samaj Sevi Sanstha	Kanker
7	D N Sharma	SANDHAN Sanstha	Bhilai
8	Paul Ratre	Jan Jagriti Manch	Raipur
9	Ajit Ekka	Jan Jagriti Manch	Raipur
10	Rajim Tandi	Chhattisgarh Gramin Seva Samiti	Mahasamund
11	Sumant Prajapati	Chhattisgarh Viklang Manch	
12	Santoshi Verma	Mitwa Mahila Kalyan Evam Sewa Samiti	Bilaspur
13	Sulakshana Nandi	Chaupal	
14	Vandana Tirky	Chaupal	Jashpur
15	Ganesh Naik	Lokshakti Samiti	Raigarh
16	Devendra Pradhan	Sajag	Mahasamund
17	Rajesh Tripathy	Jan Chetna Manch	Raigarh
18	Santh Kumar	JSS Ganiyari	Bilaspur
19	Gangaram Paikra	Chaupal Ambikapur	
20	Shalini	JSA	



21	Omprakash Burman	SHRC	Bastar division
22	Bhibhishan Patre	Jan Jagran Samiti,Pamgadh,	Janjgir Champa
23	Sandesh Kumar Ratre	Jan Jagaran Samiti, Pamgadh,	Janjgir Champa
24	Saibal Jana	Shaheed Hospital	Dalli rajhara
25	Rameshwar Sahu	Shaheed Hospital	Dalli rajhara
26	Hemnarayan Manikpuri	Lok Astha Sewa Sansthan	Raipur
27	Sumitra Dhruva	Adiwasi Jan Adhikar Sangathan	Dhamtari
28	Anita Dhruva	Adiwasi Jan Adhikar Sangathan	Dhamtari
29	R K Shah	Rachana Manch	Dhamtari
30	Kalawati Kashyap	Sahbhagi Samaj Sevi Sanstha	Kanker
31	Kanica Kanungo	Public Health Resource Network	
32	Pratik Phadkule	Public Health Resource Network	

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Website: [www.sochara.org](http://www.sochara.org)





(13)

Sama (at.)

## JSA - PANS (Participatory Assessment of Network Strengthening)

### Brief protocol for member organizations / networks of the National Coordination Committee of JSA

**Name of the organization / network:** Sama-Resource Group for Women and Health.....

**1. When did your organization / network link with JSA and join the NCC? (please give brief history including when, why, how and who were the key representatives of your organization participating in the NCC from 2000 to date)**

Sama's links with JSA began in 2000 at the time of the first People's Health Assembly in Savar, Dhaka. Sama participated in the national assembly at Kolkata (Anuj and Sreekala) and (Anuj) at PHA 1, Savar Dhaka. Deepa participated in PHA 2 at Ecuador. Sama was part of the core committee in both assemblies. Sama was also involved in the processes prior to the assembly - at the Delhi State level, Sama was involved in preparing the health chapter, signature campaigns, health status surveys, etc.

Since then, Sama has been actively involved in the state JSA as well national JSA initiatives as well as secretariat (jointly with SATHI). In 2006, Sama also became a part of the JSA – NCC based on its prior involvement and contribution. Sarojini from Sama is also a Joint Convenor in JSA.

Sama representatives who participate in recent NCCs:

Sarojini

Deepa

Beenu

**2. What has participating in the JSA meant for your organisation? (state upto three opportunities in general and all collaborative initiatives in particular)**

- The Jan Swasthya Abhiyan and the global people's health movements are, to Sama, critical to strengthening and taking forward the campaign for health rights and health for all. Sama's approach and perspectives on health largely coincide with the guiding principles of the JSA.
- ★ JSA towards strengthening campaigns and joint action fronts to inform and influence public opinion and policy. Collective processes also provide opportunities for larger outreach and impact, decentralised action and wider dissemination mobilisation around varied health issues.
- Sama has been able to contribute to shaping JSA's analysis and responses from a gendered lens as well as in raising health concerns and violations against women and marginalised.

Some of the Collaborative Initiatives with JSA include:

- Regional and national public hearings in collaboration with the National Human Rights Commission (NHRC) to highlight health care violations and ensure that action is taken to stop these and to protect and promote the right to health, including women's right to health.
- ★ Involved in analysis of policies, legislations, plans such as National Rural Health Mission (NRHM), National Urban Health Mission (NUHM), draft National Health Bill (NHB), Eleventh Five Year Plan, the People's Manifesto on Health to inform political parties towards addressing health in their manifestos.





- Involvement in the organization of the second National Health Assembly (NHA II) at Bhopal, including development of booklet on *Women's Health* and contribution to booklet on *New Technologies in Public Health: Who pays and who benefits*.
- Workshops, trainings, campaigns with state level JSA partners, JSA national networks on diverse health issues. For e.g. HPV, sex selection, assisted reproductive technologies, etc.
- Involved in studies by national level and state (Delhi) JSAs.
- Co-secretariat of national JSA and coordination of Delhi level JSA.

3. **What has been the contribution of your organisation/network to JSA? (mention all the contributions including participating in national events / initiatives and contributing reports / publications / educational materials / advocacy materials / research reports / representing JSA in other regional / national / international events / contribution to governance etc.)**

The following are examples of the contributions by Sama:

***Organisation / Participation in Events:***

National Assembly, Kolkata

PHA at Savar Dhaka

National Workshop on Right to Health Care and National Consultation on Right to Health – Health for All (2003) on the occasion on 25 years of Alma Ata.

NHRC public hearings and reviews on Right to Health Care

National Health Assembly, Bhopal

People's Health Assembly, Cuenca, Ecuador

Research Methodology workshop to document starvation deaths.

Fact finding of Barwani Maternal deaths

Lead in the campaign for the release of Dr Binayak Sen

***Policy level interventions – memorandums, statements drafted and presented.***

***Strengthening collective understanding and capacities of JSA partners on diverse health issues***

National Workshop on Urban Health

National Workshop on National Health Bill

National Workshop on Sexuality and Right to Health

Workshop on NRHM (Orissa)

Session on Right to Health, Right to Food (2002) for community based organisations (Delhi).

Workshop to build capacities of organisations (Delhi) in research, documentation as part of the study of health facilities undertaken by JSA, Delhi.

***Contribution to publications, reports:***

Booklet on *Women's Health* and contribution to booklet on *New Technologies in Public Health: Who pays and who benefits*

People's Health Manifesto

Glimpses from Grassroots (JSAD Delhi study)

GHW report (2011)

***Governance***

Part of NCC

Joint convenor (Sarojini)

State level (Delhi) coordination

4. **From your organizational / network experience what do you think have been the main strengths in relationships / experience with JSA?**





- JSA is significant at the local / regional, national and international levels and has the collective strength and reach to inform and impact health policy, plans, programmes and legislations.
- JSA provides the space to raise issues and concerns vis-à-vis health that Sama has been engaging with, providing a collective facilitation, exchange of ideas, strategies.
- The diversity of organisations, networks has facilitated mobilization, dissemination on a range of health issues and wide outreach. Sama has initiated linkages between organisations that Sama works with and state JSAs.
- JSA has provided opportunities to build knowledge and capacities and leadership of organizational (Sama) members on varied health issues.





5. **From your organizational / network experience what do you think have been the main weaknesses / obstacles in relationship / experience with JSA? Any suggestions of how they could have been overcome /should be overcome?**

- Strengthened understanding perspectives on gender, sexuality, marginalization, and other emerging issues are necessary for JSA partners; initiatives to address this at different levels must be strengthened.
- Mobilisation of organisations who are part of JSA has been a challenge in Sama's coordination and sustained involvement in Delhi. Although organisations and networks are actively engaged on diverse issues, collective action has not been easy. Experiences / strategies of states which have been able to sustain and strengthen collective action would be useful; for application in states where it continues to be a challenge.

6. **What opportunities do you see for your organisation and the JSA for collaborative functioning in the coming period?**

Sama will continue to be actively involved in JSA's initiatives, campaigns as well as in (if required) coordination, mobilization and other organizational processes, including governance.

7. **Are there any observations /suggestions that could mention as problems / challenges that could continue to affect JSA's efforts to strengthen itself?**

Communication and inter-linkages between the national and state level activities needs strengthening and streamlining. At present the only common forum where this happens to some extent is the NCC meeting.

JSA constitutes diverse organisations and networks working on very many health issues. Clarity or due process to determine when / how a campaign / issue led by JSA constituents is / becomes a "JSA issues and campaign" is important. This will facilitate strengthened action on important health issues.

8. **Does your organization / network have members that work with JSA at the state level - if so which states?**

Not applicable

9. **Are there any issues your organisation has encountered in getting involved in state level activities?**

Sama has been actively involved in state level activities of JSA from 2000. Sama has been involved in campaigns, research, advocacy and capacity building initiatives of JSAD in Delhi.

However, mobilization of JSA partner organisations has remained a challenge; both in the past, when JSAD was coordinated by other organisations, as well as more recently (last year) when Sama took on the responsibility of coordination in Delhi. Sama has been exploring strategies used in different states where JSA partners meet regularly and plan collectively for adoption in Delhi.

10. **Are there any other possibilities / opportunities of collaborative initiatives /collaborative campaigning that can be taken forward by JSA and your organisation? Give examples?**





Sama has been collaborating with JSA on myriad issues that the organisation is engaging with – public health programmes, legislation (NUHM, NRHM, National Health Bill), HPV campaign, ARTs, universal (free) access to medicines, etc.

11. Any other matter about JSA – national and state level and above NCC which you would like to raise as part of the PANS exercise?

12. List out as much of the following to supplement the information at the secretariat level. (You may use separate sheet if required:

- a. List of key organizations / networks in the state coordination committee as of 1<sup>st</sup> October 2011 (include list of office bearers and committees if any)
- b. List of events in the last two years - 2010 / 2011 (including engagement / dialogue with state government, campaigns, struggles, community action etc)
- c. List of publications in the last decade – 2001 – 2011 (of significance to JSA)
- d. List of translations in the state vernacular of international PHM / national JSA documents and publications
- e. List of key individuals who have represented your organizations / networks in JSA / NCC since 2001 (mentioned earlier)
- f. Any other information / publication / campaign materials that you would like to send to the PANS committee / secretariat

Name of respondent from organization / network: Sarojini and Deepa  
(to be contacted by PANS committee for  
further information if required

Date: 9<sup>th</sup> October 2011

\*\*\*\*\*





## JSA – PANS (Participatory Assessment of Network Strengthening)

Brief protocol for member organizations / networks of the National Coordination Committee of JSA

Name of the organization / network: **ALL INDIA DRUG ACTION NETWORK**

1. When did your organization / network **link** with JSA and **join** the NCC? (Please give brief history including when, why, how and who were the key representatives of your organization participating in the NCC from 2000 to date)

As I was Founding Member of JSA PHA 2000 at the initial discussion in Chennai when Dr. Zafrullah and Dr. Qasem came, formal representation followed, representing VHA1 till 2005 and AIDAN. So engagement with JSA was at 3 levels as VHA1 as AIDAN and as myself on issues beyond Health and Drugs eg. Training of JSA activists in Hyderabad, later Bhopal, Calcutta. Being a Founder member of PHM associated with its initiation, since the very first discussion on the idea in 1986 at the WHA, also as HAIAP representative association in PHM, the engagement has been continuous.

2. What has participating in the JSA meant for your organization? (state upto three **opportunities** in general and all collaborative initiatives in particular)

Since AIDAN focuses mainly on Drugs issue contribution in the Essential Drug Booklet in the Drugs Workshops held in NHA1, NHA2 and collaborating partners in Drugs Seminar in Calcutta, in Delhi. Involvement in the formulation of the National Health Charter when this exercise was undertaken in ISI with Dr D Banerji, Dr C Sathyamala & many others  
Had contributed in the Training program in Hyderabad pre NHA 1.

3. What has been the **contribution** of your organization / network to JSA? (mention all the contributions including participating in national events / initiatives and contributing reports / publications / educational materials / advocacy materials / research reports / representing JSA in other regional / national / international events / contribution to governance etc.)

★ **Contribution in Drugs Workshops** NHA1, NHA2. In Drug seminars as co-organizers in Calcutta, drafting of Calcutta Declaration. In Delhi.

Contribution to the Drug Booklet,  
Women and Health booklet.

Prepared the Elderly section of the Vulnerable sections of Society. The other 2 sections were Tribals by sr Prabha CHAI & Dalits by Prem das CHC. Unfortunately for some reason this booklet was not published.



★ Represent JSA in Right to Food Campaign with Vandana Prasad. Have participated in RTF meets in Bodh Gaya, in Rourkela, advocacy effort, protests at Jantar Mantar , Planning Meetings , Steering Committee Meetings .

Worked with Sewage Workers Association attending their meetings as JSA representative .

In Global Health Governance meeting organized by Narendra in Surajkund as PHM India. Attended almost all JSA-NCC meetings Dharamshala Mumbai , Pius Seminary Mumbai, CMAI Delhi , ISI Delhi , USO House Delhi , Bangalore, Paschim Banga Calcutta, Bhopal.

JSA workshops Asian Social Forum Hyderabad coordinated by Ravi , Thelma CHC , Indian Social Forum JSA activities release of booklets , panel discussant on Dengue organized by JSA Delhi .

JSA NHRC Meet in Habitat Centre , . Pursued with NHRC supporting JSA Right to Health Public Hearing Proposal

Attending JSA NCC meetings have been always involving out of pocket expenditure for tickets & taking of leave when

4. From your organizational / network experience what do you think have been the main **strengths** in relationships / experience with JSA?

With JSA on some of the issues of concern have been able to pursue them eg. Engagement with Right to Food Campaign which has been a meaningful engagement , specially as over the years broadening of the collective understanding has taken place , eg to look beyond ICDS , PDS but food Security , Food Sovereignty , agrarian crisis , farmers suicides , control of seeds , Health hazards related to GM , Pesticides .

Similarly engagement with Sewage Workers has been important because it showed the neglect of Occupational Health issues in Policy & Programs & the need for greater support of those involved & struggling to get these concerns addressed.

5. From your organizational / network experience what do you think have been the main **weakness** / obstacles in relationship / experience with SA? Any suggestions of how they could have been overcome / should be overcome?

Decision making often arbitrary, based on individuals decisions not any processes and procedures.

Sincere, serious feedback not taken seriously. eg issue of Land Acquisition, land grab , across the states, with numerous grassroots movements fighting for survival of the tribal peoples right to their livelihood , home . This was a crucial issue as case after case has shown that the poor who are forcibly displaced

Non inclusion of many who have contributed significantly to the health movement and health and human rights efforts who have been associated with JSA in the past & would have liked to have been associated .

Need for transparency and use of strengths of various organizations networks.

6. What **opportunities** do you see for your organization and the JSA for collaborative functioning in the coming period?

AIDAN has been involved with the Drugs issues since early 80's and continues to be engaged with it. Sincere collaboration with JSA partners engaged in Drugs issue and AIDAN to have a



strong core based on trust and **collective working together** is possible and is a necessity keeping in mind the tremendous coordination of the pharma sector.

7. Are there any observations / suggestions that could mention as problems / **challenges** that could continue to affect JSA's efforts to strengthen itself?

Not having involved pro actively and benefitted from the tremendous experiences of Dr. Arole, Dr. Antia and many others remains a deep regret as they were the pioneers of Comprehensive Primary Health Care in India. Their institutions could have been used of training discussion on contemporary health challenges but also exposure and orientation of many who had not had experience working in community health.

8. Does your organization / network have members that work with JSA at the state level – if so which states?

LOCOST Gujrat

DAFK Karnataka

CDMU West Bengal

VHAI was AIDAN secretariat. TNVHA, KVHA, MPVHA which were actively involved in state JSA were also associated with AIDAN. There are several individuals associated with AIDAN linked with JSA Drug activities. Dr. CM Gulati, Late Dr. W V Rane, many others then involved linked to state dynamics and VHAI dynamics.

9. Are there any issues your organization has encountered in getting involved in state level activities?

10. Are there any other possibilities / **opportunities** of collaborative **initiatives** / collaborative **campaigning** that can be taken forward by JSA and your organization? Give examples?

Definitely on the Drugs issues

Rational Use of Drugs

- Novartis issue-Glivic Case , Conflict of Interest
- Pharmaceutical policy
- ★ - Unethical Clinical Trials
- Essential Drugs and Drug Pricing
- Irrational and Hazardous Drugs
- IPR issue
- Drug Safety issue "counterfeit "
- FTA
- MCI – Medical Education

11. Any other matter about JSA –national and state level and above NCC which you would like to raise as parts of the PANS exercise?

Improve communication for sense of inclusion . not just sending of decisions taken by few.

Review decision making –eg who decided about the National Coordinator ? What was the criteria ? Who all were consulted ? Why mid course correction not undertaken ?

12. List out as much of the following to supplement the information at the secretariat level.  
(You may use separate sheet if required:

- a. List of key organizations / networks in the state coordination committee as of 1<sup>st</sup> October 2011 (include list of office bearers and committees if any)
- b. List of event in the last two years – 2010 / 2011 (including engagement / dialogue with state government, campaigns, struggles, community action etc)
- c. List of publications in the last decade – 2001 – 2011 (of significance to JSA)
- d. List of translations in the state vernacular of international PHM / national JSA documents and publications
- e. List of key individuals who have represented your organizations / networks in JSA / NCC since 2001
- f. Any other information / publication / campaign materials that you would like to send to the PANS committee / secretariat

a. DAFK – Dr. Gopal Dabade, Convenor, Jan Arogya .

b. Novartis Case , PILs on Drug Pricing & Essential Drugs , PIL on Closure of 3 Public Sector Units

C publications – by AIDAN & Member organizations

AIDAN drug Pricing booklet , Layman's Guide by Locost ,

Drug Pricing S Srinivasan & Dr Anurag Locost

Anaemia Booklet Dr Gopal Dabade DAFK ,

BODHI Rational Drug Use journal by Health Action Foundation Dr PK Sarkar

Banned & Bannable Drugs 5<sup>th</sup> Revision Late Dr Wishwas Rane , Dr Mira ShivaVHAI

D translations on issues

E Dr. Gopal Dabade, S Srinivasan, Dr. Anant Phadke in JSA Drug Activists, Co-convenors involved in JSA Drug action , meetings & Conferences , some of which have been as collaboration with CDMU , JSA , AIDAN etc in Calcutta , Delhi etc

Public Interest Litigations PIL's in Supreme Court by AIDAN along with others MFC , Locost JSS associated with State & National JSA

- Essential Drugs and Drug Pricing
- Closure of 3 vaccine PSUs



- New Vaccine inclusion in National Immunization Program ,Criteria needed & also National Rational Vaccine Policy

More material can be sent later .





## JSA - PANS (Participatory Assessment of Network Strengthening)

Brief protocol for member organizations / networks of the National Coordination Committee of JSA

Name of the organization / network : .....

1. When did your organization / network **link** with JSA and **join** the NCC? (please give brief history including when, why, how and who were the key representatives of your organization participating in the NCC from 2000 to date)

2. What has participating in the JSA meant for your organization? (state upto three **opportunities** in general and all collaborative initiatives in particular)

Ans. We have been associated as a HEALTH WATCH FORUM network member.

- Great opportunity to participate in the one day workshop organized by JSA to review NRHM .

3. What has been the **contribution** of your organisation/network to JSA? (mention all the contributions including participating in national events / initiatives and contributing reports / publications / educational materials / advocacy materials / research reports / representing JSA in other regional / national / international events / contribution to governance etc.,)

Ans 3. HEALTH WATCH FORUM is associated with this national network for quite a long time and have contributed in many ways.

- Inviting this network to jointly protest against the Private Public Partnership.
- Many network members of Uttar Pradesh joined a Manch " *Swasthya Sewa Nijikaran Virodhi Manch*".
- We have developed the Parcha which was made very simpler in Hindi language to distribute the poor people such as Auto Wala's Rickshaw wala's to convey the message to the poor/marginalized.
- We have done a lot of research work/data on maternal health was very helpful to JSA.

4. From your organizational / network experience what do you think have been the main **strengths** in relationships / experience with JSA?

Ans. 4. Attending the meetings and workshops. (regular meetings on occasion of World Health day)

5. From your organizational / network experience what do you think have been the main weaknesses / obstacles in relationship / experience with JSA? Any suggestions of how they could have been overcome / should be overcome?

Ans. 5. The decisions should be more participatory.

6. What opportunities do you see for your organisation and the JSA for collaborative functioning in the coming period?

Ans 6. It's a national network and we see great opportunities to work together to take the issue of "Women's reproductive Health and Rights".

7. Are there any observations / suggestions that could mention as problems / challenges that could continue to affect JSA's efforts to strengthen itself?

Ans. Its already a strong National level network, it would be our great opportunity to remain associated with this network.

8. Does your organization / network have members that work with JSA at the state level - if so which states?



9. Are there any issues your organisation has encountered in getting involved in state level activities?
10. Are there any other possibilities / **opportunities** of collaborative **initiatives** /collaborative **campaigning** that can be taken forward by JSA and your organisation? Give examples?
11. Any other matter about JSA – national and state level and above NCC which you would like to raise as part of the PANS exercise?

12. List out as much of the following to supplement the information at the secretariat level. **(You may use separate sheet if required:**
- List of key organizations / networks in the state coordination committee as of 1<sup>st</sup> October 2011 (include list of office bearers and committees if any)
  - List of events in the last two years - 2010 / 2011 (including engagement / dialogue with state government, campaigns, struggles, community action etc)
  - List of publications in the last decade – 2001 – 2011 (of significance to JSA)
  - List of translations in the state vernacular of international PHM / national JSA documents and publications
  - List of key individuals who have represented your organizations / networks in JSA / NCC since 2001
  - Any other information / publication / campaign materials that you would like to send to the PANS committee / secretariat

Name of respondent from organization / network  
(to be contacted by PANS committee for  
further information if required)

Date :

\* \* \* \* \*





# JSA - PANS (Participatory Assessment of Network Strengthening)

## Brief protocol for member organizations / networks of the National Coordination Committee of JSA

### Name of the organization / network: **Breastfeeding Promotion Network of India**

1. When did your organization / network **link** with JSA and **join** the NCC? (please give brief history including when, why, how and who were the key representatives of your organization participating in the NCC from 2000 to date)

Breastfeeding Promotion Network of India joined Jan Swasthya Abhiyan Network in a meeting held in Chennai in 2002. As BPNI has been involved in advocacy for legislative protection of breastfeeding and monitoring of the *Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003*, we felt it is pertinent to link with JSA and Dr. Vandana Prasad introduced BPNI to JSA NCC. Since then, either I, or Dr JP Dadhich or Radha Holla have been participating. We have been raising issues on child malnutrition and conflicts of interests. BPNI is part of the process developing the position paper on Safe delivery.

2. What has participating in the JSA meant for your organisation? (state up to three **opportunities** in general and all collaborative initiatives in particular)

BPNI has worked with JSA on three major issues: breastfeeding and its protection from commercial interests, and its support in health system; child malnutrition, with special focus on severe acute malnutrition, and conflicts of interest. However, these initiatives till now have not seen much result as either discussion or coming to a consensus position, though the latter two initiatives have seen collaboration with individuals from JSA, specifically Dr. Vandana Prasad, S. Srinivasan (LOCOST and MFC Bulletin) and Dr. Amit Sengupta. BPNI is also collaborating with JSA in the Right to Food Campaign Steering Committee, and is part of the Working Group on Children under 6 – an interface between JSA and RTF.

3. What has been the **contribution** of your organisation/network to JSA? (mention all the contributions including participating in national events / initiatives and contributing reports / publications / educational materials / advocacy materials / research reports / representing JSA in other regional / national / international events / contribution to governance etc.,)

BPNI has consistently raised the issue of protection of breastfeeding, child malnutrition and conflict of interests at JSA NCC meetings. BPNI was co-organiser of a workshop on Children's Right to Food, held in Bhopal during the 2<sup>nd</sup> National Convention in March 2007. In addition, BPNI raised the issue of the need to protect against conflict of interest in the framework draft National Health Bill, including informing JSA on the issue in meetings held in New Delhi. Further, BPNI was a part of the development of vaccine paper but it was not finalized. BPNI has been consistently sharing its research findings and advocacy materials and results with the JSA.

4. From your organizational / network experience what do you think have been the main **strengths** in relationships / experience with JSA?

One major strength that our experience with JSA is that it has strengthened our relationship with the network, and specifically with individuals. The various discussions that take place in the e-group throw light on several issues that are either directly or indirectly connected with the issues we work on, and often inform our positions in our own area of work.



5. From your organizational / network experience what do you think have been the main **weaknesses** / obstacles in relationship / experience with JSA? Any suggestions of how they could have been overcome / should be overcome?

We appreciate that JSA members have a diversity of opinions, and are engaged in working on several aspects of health, which often do not coincide with the areas we are working on. However, certain issues, especially conflict of interest, underpins almost all of health issues, including social determinants of health. Further, issues like child malnutrition and survival are directly linked with infant and young child feeding practices. We still are unable to elicit responses to issues we work on – breastfeeding and IYCF, child malnutrition and conflicts of interest – from the majority of the network members. We feel that we and our areas of concern are considered outsiders.

We believe these issues need to be taken up as JSA campaigns; this means that JSA would have to come to a common position, and that we need to find a common ground of action which could be owned by JSA along with the concerned network and publication of reports under joint heads.

6. What **opportunities** do you see for your organisation and the JSA for collaborative functioning in the coming period?

We see our membership in the JSA network as of pivotal importance in both informing and being informed of the various concerns in public health. We already see the interest in the network on specific areas we work on – especially monitoring of the IMS Act for violations and conflict of interest. We would like to collaborate further with JSA on these issues, including designing campaigns and action on these issues for a start.

7. Are there any observations / suggestions that could mention as problems / **challenges** that could continue to affect JSA's efforts to strengthen itself?

We feel that loose networks like JSA have several strengths, including bringing diverse view points. However, coming to a position could be time consuming, especially when the challenges posed by both the state and its liberalization policies do not allow the luxury of time for developing responses. A workable possibility is that working groups are formed to develop positions, which are then endorsed by the NCC, and the larger JSA network (and in some cases this has already happened, eg. Women's health, under 6s), from which JSA campaigns can be developed. These working groups will go a long way to improve the current loose coordination and thus improve the stability of the network. It will also lessen the feelings of alienation from JSA. It requires better coordination.

8. Does your organization / network have members that work with JSA at the state level - if so which states?

BPNI has more than 3500 members, network members may not be active to participate in State level meetings and they would need more than political education of the issues, but of course if there is an issue that is of common ownership between the JSA and member network I am sure some people can be involved.



9. Are there any issues your organisation has encountered in getting involved in state level activities?

BPNI has encountered several problems of legitimacy at state level.

10. Are there any other possibilities / **opportunities** of collaborative **initiatives** /collaborative **campaigning** that can be taken forward by JSA and your organisation? Give examples?

As said above, monitoring of the *Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003* and conflict of interest.

11. Any other matter about JSA – national and state level and above NCC which you would like to raise as part of the PANS exercise?

12. List out as much of the following to supplement the information at the secretariat level. (You may use separate sheet if required:

- a. List of key organizations / networks in the state coordination committee as of 1<sup>st</sup> October 2011 (include list of office bearers and committees if any)
- b. List of events in the last two years - 2010 / 2011 (including engagement / dialogue with state government, campaigns, struggles, community action etc)
- c. List of publications in the last decade – 2001 – 2011 (of significance to JSA)
- d. List of translations in the state vernacular of international PHM / national JSA documents and publications
- e. List of key individuals who have represented your organizations / networks in JSA / NCC since 2001
- f. Any other information / publication / campaign materials that you would like to send to the PANS committee / secretariat

12. As our issues do not seem to be of much significance to JSA, most of the above does not apply.

12.e. Dr. Arun Gupta, J.P. Dadhich and Radha Holla have been representing BPNI in JSA/NCC.

Name of respondent from organization / network  
(to be contacted by PANS committee for  
further information if required Radha Holla

Date : 17<sup>th</sup> Oct 2011

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# JSA - PANS (Participatory Assessment of Network Strengthening)

Brief protocol for member organizations / networks of the National Coordination Committee of JSA

Name of the organization / network : Society for Community Health Awareness, Research and Action (SOCHARA), No. 326, 5<sup>th</sup> Main, 1st Block, Koramangala, Bangalore – 560 034

1. When did your organization / network **link** with JSA and **join** the NCC? (please give brief history including when, why, how and who were the key representatives of your organization participating in the NCC from 2000 to date)

SOCHARA had early in its history since 1984 committed to work on health rights and towards Health for All. We were therefore active in many national and other networks including MFC, AIDAN, ACHAN, ISI, CHAI, CMAI etc. SOCHARA articulated the need for a counter veiling power nationally and globally if Health for All goals were to be met. It therefore has been an active founding member of JSA and has participated in setting up the NCC. We had a discussion on the proposed first Peoples' Health Assembly at a meeting of the **International Poverty and Health Network (IPHN) in 1999 organised by CHC SOCHARA in Bangalore where Zafrullah Choudhry from Gono Shasthya Kendra (GK) one of the 8 organisers and the hosts of PHA 1 made a presentation.** SOCHARA made an organizational commitment through its EC and AGBM as well as through team discussions to fully support the Assembly and the movement. We subsequently proactively contacted BGVS, CHAI, MFC and other networks with whom we had been working since the early 1980s. Ravi Narayan became the representative in national meetings providing leadership to the groups together with Sunderaraman from BGVS. There was active participation and support by Thelma Narayan, who was then Secretary SOCHARA with Dr. CM Francis, and team members such as SJ Chander, Prasanna Saligram, Abraham, Prahlad, Paresh Kumar, Naveen Thomas in Karnataka and Rajendran in Tamil Nadu supported by the entire team played a very active role in developing state level units. CHC and SOCHARA played a role in bringing in and supporting networks and in keeping diverse groups together over the years. There was proactive participation in developing the five background booklets to the first Jan Swasthya Sabha in Kolkotta. **The community health internship and fellowship program during which the five booklets are discussed along with other issues have oriented many over a 6 – 12 month period.** Alumni and newer team members such as Ameer Khan and Rakhal Gaitonde have played a significant role in Tamil Nadu. The entire team and Juned Kamal supported the second national Health Assembly and MP JSA. CHC also worked with the AP JSA group and helped in the inclusion of the Positive Women's Network. The Dalit voice and issue has consistently been supported in Karnataka and Tamil Nadu. Obalesh has been involved since 2003 and with Premdas there has been a strong focus since 2008 at strengthening district level units, supported by Karibasappa, Manjula, Hanumanthappa. Presently Joyce, Prahlad, Shilpa are active in Jana Arogya Andolana Bangalore Urban (JAABU) which was set up in 2001-2. Sudha Nagavarapu one of our CH Alumni is the nodal person for JAABU supported financially by other partner organisations.

The 25 members of SOCHARA and the entire team in Bangalore, Chennai and Bhopal are supportive of the involvement in JSA related activities.

2. What has participating in the JSA meant for your organisation? (state upto three **opportunities** in general and all collaborative initiatives in particular)

- The Health for All movement to which we are organizationally committed has grown with JSA emerging as a national level platform and PHM as a global group
- Campaigns at national level and PHM initiatives at global level have been supported by us and this has provided an opportunity for everyone involved to grow



- c) Engagement with the public health system has also gained in strength with JSA involvement both in Karnataka - with the Karnataka Task Force on Health and Family Welfare and through the NRHM processes

Collaborative initiatives are mentioned below

3. What has been the **contribution** of your organisation/network to JSA? (mention all the contributions including participating in national events / initiatives and contributing reports / publications / educational materials / advocacy materials / research reports / representing JSA in other regional / national / international events / contribution to governance etc.,)

- a) SOCHARA was an active/ proactive founding JSA member
- b) We have played a role in getting other networks engaged with the movement
- c) We have been involved with writing some of the documents and in translations
- d) We have been consistent in support over the decade from 2000 till date at local, state to global level
- e) Resources were raised for JSA – human, organizational and financial
- f) We have been responsible and active members of the national working group and NCC
- g) CHC SOCHARA has played a key role in Karnataka and Tamil Nadu JSA units over the decade
- h) We participated actively in the Right to Health campaign with SAATHI, PRAYAS and others, taking responsibility in Tamil Nadu and continuing in 450 village panchayats in 6 districts in an intense way through partnerships with like-minded NGOs and with the state level; and in Karnataka through the pilot phase and subsequently in an independent way.
- i) CHC SOCHARA hosted the global PHM secretariat from 2003-2006 on behalf of JSA
- j) We have on invitation represented PHM/ JSA in several meetings
- k) Ravi is a member of the PHM steering council and was earlier active on the CoCo.
- l) We have been active in the IPHUs (International People's Health University) – the first IPHU in Cuenca in 2005; helped the Cairo group in organisation of the Bhopal IPHU in 2007; participated in the Jaipur IPHU in 2008; organized the Bangalore IPHU in 2009 with PRAYAS & JSA; Ravi spoke at IPHUs in London when he was there for other visits
- m) We have been part of the Research Circle of PHM and (i) spoke in the Research Encounter in Cuenca held before PHA 2; (ii) were the Asian hub for the PHM led research study on 'Revitalising Health for All – learning from Comprehensive Primary Health Care' with five Asian teams over a four year period from Iran, Pakistan, Bangladesh and India. This was with the University of Ottawa with Ron Labonte and group and University of Western Cape with David Sanders and group. We hosted the 2 week research training in Bangalore for the teams in 2008, subsequent trainings in Dhaka and Colombo and dissemination in WHO and India; (iii) support young researchers in our group and others in their work. (iv) Participated in the Measurement and Evidence Knowledge Network of the WHO Commission on Social Determinants of Health.
- n) We were part of the PHM HIV AIDS circle and helped in evolving the PHM Charter on HIV AIDS launched at the Bangkok meeting in 2004. This was based on prior involvement in the issue.
- o) We were active members of the PHM WHO circle engaging from 2001 onwards helping to place HFA and comprehensive primary health care back on the agenda through a series of meetings and various forms of engagement.



4. From your organizational / network experience what do you think have been the main **strengths** in relationships / experience with JSA?

The analytical ability of the JSA national group based on the many years of work is a great strength. The grounded nature of work of the constituents including the diversity is also a strength that not many other country circles of JSA have. The different movements such as the women's movement, science movement, environment movement and their traditions of analysis and action have enriched the JSA. We have experienced the collegiality of working together successfully in a collective manner over the years. Tensions that do surface have been handled fairly positively. There are abilities to work with communities to help realize rights, to develop a critical and constructive engagement with government, to influence policy and programs, and to take responsibility at a global level (most recently with Global Health watch 3) and in the Rio Conference on Social Determinants of Health.

5. From your organizational / network experience what do you think have been the main **weaknesses** / obstacles in relationship / experience with JSA? Any suggestions of how they could have been overcome / should be overcome?

- a) There has been a weakening of the JSA collective leadership over the past few years with inadequate clarity about campaigns and support mechanisms required in the current global and national context. In a contrary statement I would say the collective leadership of JSA has also been a strength and this has been recognized at various levels including globally. We have also been able to influence change at local, state and national level.
- b) The sense of solidarity and communication between and across state units needs to improve. We tend to be linguistically and regionally limited. The underlying determinants of health are however local, regional, national and global and they need to be addressed.
- c) JSA has much to contribute to the global PHM and thus participate in a proactive manner in addressing crucial issues such as corporate led globalization particularly its financial component. Some JSA network members are active in this, but this could be now engaged with in a larger manner.
- d) Gender issues within the movement also need attention.
- e) Younger and newer member individuals and organisations need space. Democratic forms of functioning need to be enhanced.
- f) Some organisations perceive a domination by certain groups/ networks/ ideologies and therefore these organisations/ networks and individuals who are equity oriented have kept away or withdrawn from active participation.
- g) JSA is not in touch adequately with other like-minded movements and groups eg the Disability Movement that has been in the forefront of the UNCRPD (UN Convention for the Rights of Persons with Disability) and the revision of the Disability Act, 1995. The mental health movement is also gaining strength and influencing change.
- h) There is inadequate open reflection in a healthy manner (which can lead to positive growth in the movement).
- i) The background material produced in 2000, 2007 and later is inadequately utilized.
- j) There are other points – which can be discussed later.

There is a need for stronger leadership at national level with broad-based linkages, closer communication, inclusive and transparent decision making and a range of skill sets. Some organisations/ networks will need to commit time. A few full timers with experience will be required. For this basic funding is necessary. Senior activists could provide space and time for discussion. JSA will need to avoid capture by different interests. A working group could be set up with changes in persons every few years. The e-group /list serve needs moderation by a group who commit time to it. We need to communicate more effectively. There is a need to organize campaigns and events as this gives an opportunity for groups to work together.



Strong state units as in Maharashtra, Gujarat, Rajasthan, Karnataka and Tamil Nadu are essential. They need to feel connected to the national and global JSA/PHM through involvement and communication. Other states need to be energized also by the national leadership.

The Nagpur meeting and subsequent meetings will we are sure reflect on the global PHM evaluation and the review of the Right to Health Campaign. These reports should be widely disseminated.

6. What **opportunities** do you see for your organisation and the JSA for collaborative functioning in the coming period?

- a) Through the civil society oriented school of public health – we look for participation in diverse ways that can be discussed if JSA is interested.
- b) Continued involvement will be there with JSA in Karnataka (JAAK), Tamil Nadu (MNI) and MP, based on collective decisions within these units and within our team.
- c) We would be interested to be involved with research based work of JSA.
- d) We would support campaigns and other work of JSA.
- e) We are a part of the group engaging with the public health system – presently ensuring participation, equity etc in the mental health policy, in AYUSH and public health, and in the NRHM.
- f) Support and involvement in the national JSA will be contingent on how processes evolve.

7. Are there any observations /suggestions that could mention as problems / **challenges** that could continue to affect JSA's efforts to strengthen itself?

If member groups or individuals get limited by their own analysis or develop a rigid approach to diverse ways of engagement it may lead to a weakening of the movement. If fatigue develops and we fail to grow and expand and respond to situations we will become irrelevant. The movement should also be wary and not become an 'old boy old girl' network with self interest entering in. Our wider social accountability needs to be kept in mind.

8. Does your organization / network have members that work with JSA at the state level - if so which states?

Karnataka, Tamil Nadu, MP

9. Are there any issues your organisation has encountered in getting involved in state level activities?

We have been proactive in Karnataka and Tamil Nadu since several years and in MP more recently. We have been cautious to minimize the development of dependency. We have also attempted to create trust between the different groups who may have different understandings, perspectives and experience in the health movement. This requires conscious effort. Field activists need support that needs to be planned and even budgeted. Burnouts can happen and a supportive framework of functioning is very helpful.

10. Are there any other possibilities / **opportunities** of collaborative **initiatives** /collaborative **campaigning** that can be taken forward by JSA and your organisation? Give examples?

Based on our experience over the decades we are developing a civil society oriented SOCHARA school of public health for the training of scholar activists. Many JSA member organisations and individuals are already involved in various ways. We would welcome further collaboration in this.



There is a need for a public health watch and an observatory on privatization trends in health related policy and health care which can feed into campaigns on these issues. Studies on disparities in health and health care, and the pathways by which the underlying determinants of health operate are needed with the necessary capacity building for this purpose. We would welcome collaboration with JSA in this as part of our shared goal of working towards greater Social Justice in Health and Development.

11. Any other matter about JSA – national and state level and above NCC which you would like to raise as part of the PANS exercise?

12. List out as much of the following to supplement the information at the secretariat level. **(You may use separate sheet if required:**

- a. List of key organizations / networks in the state coordination committee as of 1<sup>st</sup> October 2011 (include list of office bearers and committees if any)
- b. List of events in the last two years - 2010 / 2011 (including engagement / dialogue with state government, campaigns, struggles, community action etc)
- c. List of publications in the last decade – 2001 – 2011 (of significance to JSA)
- d. List of translations in the state vernacular of international PHM / national JSA documents and publications
- e. List of key individuals who have represented your organizations / networks in JSA / NCC since 2001
- f. Any other information / publication / campaign materials that you would like to send to the PANS committee / secretariat

We have archives and reports of activities over the years in our office in Bangalore. There is some documentation also in our Chennai and Bhopal centres.

Name of respondent from organization / network **Thelma Narayan, Secretary, SOCHARA**

Date : 10/11/11

(to be contacted by PANS committee for further information if required

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(18)

AIDWA

Q.6.

## Questionnaire

### 1) Participation in activities of JSA

Which activities of JSA, co-ordinated at the national level, have you been associated with (you can add your comments of the role you played in these activities).

#### a) Pre-National Health Assembly 1 (held in Kolkata in December 2000) activities in 2000

AIDWA was an active participant in the regional, state level activities preceding the NHA. Our units intervened on social parameters affecting health like sanitation and safe drinking water, and also in the monitoring of health delivery systems at the local/tehsil level.

#### b) National Health Assembly 1 in Kolkata in 2000

A sizeable number of AIDWA activists took part in the Kolkata Conference, and we also co-ordinated the parallel session on women and violence. National office bearer, Sudha Sundararaman addressed the inaugural session on behalf of AIDWA. Papers were presented in other sessions as well.

#### c) Right to Health Public Hearings (Jan Sunwai) in 2004-2005

AIDWA took part in some states like Chennai, and Maharashtra. But its main activities on health have been undertaken independently.

#### d) NRHM watch in 2007-2008

AIDWA has been taking up the problems of the ASHA workers, along with the CITU, in a number of states.

#### e) Pre-National Health Assembly 2 (held in Bhopal in March 2007) activities in 2007

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**f) National Health Assembly 2 in Bhopal in March 2000**

Around 35 delegates from AIDWA took active part in the NHA-2. A paper was presented at the Women and health parallel session. The participants took part in the several workshops held on diverse topics.

Any other (including state JSA programmes), please list:

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**2) Experience of participating in JSA activities**

Please write a few lines of the experience (positive or negative) of participating in activities of the JSA, including suggestions about how the activities could be better organised.

AIDWA has found that being part of the JSA is helpful in many ways. On the basis of sharing multiple experiences from the ground, a broader perspective evolves. Organizations working on different aspects of health are able to get a wider exposure to diverse issues. In the current situation, a larger unity of forces is required to make an impact on health policy, and to ensure proper implementation of public health programmes.

**3) Organisational Structure and co-ordination in JSA**

Give your opinion about the organizational structure and co-ordination within JSA in your state at present. Discuss how it can be improved and strengthened.

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#### 4) Activities of your organisation in the health sector

List activities of your organisation (or as individual) in the health sector – this includes activities beyond those co-ordinated by the JSA

AIDWA had been taking up diverse issues relating to health and well being. One important focus has been on vaccines, and we had opposed the closure of the public sector vaccine production units in Tamil nadu and HP in a big way. These production units are now being reopened, so it was a successful struggle. AIDWA has been active on the clinical drug trials issue, and we had mobilized around the issue of HPV vaccines being administered in an unethical manner in AP, etc.

AIDWA has also focused on sex selection, and has been fighting for the effective implementation of the Pc PNDT Act to arrest the decline in child sex ratios.

Issues of sanitation, protected drinking water, proper facilities in the public hospitals, are taken up widely at the area level.

#### 5) Activities of your organisation in relation to NRHM

Has your organisation been associated in any programmes of the NHRM? Discuss from the list below or add if there are any others:

##### a) Community Monitoring

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b) Training of ASHA

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c) Formation of Village Health and Sanitation Committees

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d) Any others (list and discuss)

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## 7) Future activities of JSA

List the activities, in your opinion, that can be a priority for the state JSA and the national JSA.

We will submit this separately, after a discussion.



# JSA - PANS (Participatory Assessment of Network Strengthening)

Brief protocol for member organizations / networks of the National Coordination Committee of JSA

Name of the organization / network : CATHOLIC HEALTH ASSOCIATION OF INDIA

1. When did your organization / network **link** with JSA and **join** the NCC? (please give brief history including when, why, how and who were the key representatives of your organization participating in the NCC from 2000 to date)

CHAI has been a part of Jan Swasthya Abhiyaan/People's Health Movement (JSA/PHM), since the inception of JSA/PHM in the year 2000. CHAI coordinated various activities and events organized as part of JSA/PHM; and participated extensively in the People's Health Assembly I (organized as part of JSA/PHM) in 2000 at Dhaka, Bangladesh.

Currently (and also since the inception of JSA/PHM), CHAI is a member of National Coordination Committee of JSA/PHM.

Rev Dr Sebastian Ousepparampil, Ex-Director CHAI was the convener of the State Unit of Andhra Pradesh.

2. What has participating in the JSA meant for your organisation? (state upto three **opportunities** in general and all collaborative initiatives in particular)

1. Able to join hands with NHRC.

2. Through partnership with JSA, CHAI collaborated with Bill and Linda Gates foundation in implementing the IHI advocacy program.

3. CHAI joined in the "One million Signature Campaign on Health for all Now", and raised eight lakhs signatures.

**Campaign against the practice of sex selective abortions.** In the context of the Public Interest Litigation regarding PNDT (Prenatal Diagnostics Techniques, prevention of misuse Act, 1994) and Sex selective abortions filed in Supreme Court, CHAI was a part of JSA organized national Policy dialogue on this issue in April 2001. Some states subsequently took up actions related to constitution of appropriate authorities, registration of Ultrasound centres, ban on advertisements, displaying posters in clinics and the issue of son preference.

**World Health Day on April 7<sup>th</sup> 2002** was observed as 'Health Rights Day', with various JSA constituents in different states, by raising the issue of **health rights** and emphasizing the recognition of health rights as human rights.

**CHAI as JSA associated organisation had a major involvement in the Right to Food campaign.** In the context of a Public Interest Litigation filed by PUCL Rajasthan in the Supreme Court and an emerging campaign, the Bharat Gyan Vigyan Samiti (BGVS) initiated action on Mid-day meal schemes in February 2002. Subsequently, in several states, surveys were conducted by JSA constituents on the status of mid-day meal and other schemes. **In some states, a convention on 'Right to food – Right to health' was organised on April 7<sup>th</sup> 2002.**

★ During the Asian Social Forum at Hyderabad in January 2003, CHAI along with Jan Swasthya Abhiyan constituent organisations conducted **several workshops/ seminars on key health issues, with facilitation by JSA.**

★ CHAI was a part of JSA 'Hunger Watch' group consisting of public health and nutrition experts was formed in 2003, which has prepared a draft protocol to investigate cases of Hunger-



related or starvation deaths. This group conducted a national workshop for activists on the method of investigating and addressing hunger related deaths, in August 2003 at Bhopal.

★ In January 2004, an **International Health Forum (IHF)** was organised by the global People's Health Movement and locally hosted by Jan Swasthya Abhiyan in Mumbai in which CHAI participated. Over 600 health experts and activists from nearly 50 countries attended this two-day forum, organised in continuity with the **World Social Forum**, which was also in Mumbai in January 2004. JSA participated in the World Social Forum as a coalition.

→ On 12<sup>th</sup> March 2004 the JSA organized a public dialogue on Health issues with representatives of various political parties. Around 300 people attended the public dialogue including members from different political parties and the media, both print and electronic. JSA representatives initially presented a specially prepared policy brief, which outlined the current health scenario and called for specific political initiatives in health care- most important of which was making health a fundamental right and increasing the budgetary allocation for public health. The politicians then shared their perceptions related to health care with a panel of social, legal, economic and health care experts. CHAI was a part of this.

→ CHAI participated in the **Peoples tribunal on population policies held at Delhi**, organized by Human Rights Law Network, Health Watch – UP, Bihar, Jan Swasthya Abhiyan and Sama – Resource Group for Women & Health.. Nearly 70 women from 15 states such as Uttar Pradesh, Rajasthan, Himachal Pradesh, Madhya Pradesh, Haryana, Tamil Nadu, Gujarat and Bihar assembled in Delhi to depose before a Public Tribunal comprising leading personalities and activists. On the pretext of promoting small family, as many as 4,000 men and women from the states of Rajasthan, Madhya Pradesh, Chhattisgarh and Haryana have been disqualified from various Panchayat positions on the grounds of infringement of the two-child norm. Nearly 120 men and women affected by the coercive policies from 14 states deposed before the panel and expressed the anger, severe pain and humiliation that they experienced in the process.

→ **Drug policy seminar:** JSA with the help of its constituent network organizations focusing on the pharmaceutical policy (Federation of Medical Representatives' Association of India- FMRAI, All India Drug Action Network – AIDAN) and the National Campaign Committee for Drug Policy – NCCDP together organised a National Seminar on 16<sup>th</sup> – 17<sup>th</sup> April 2005 in Kolkata on 'Pharmaceutical Policy in India and Access to Essential Drugs.' Over one hundred delegates from different parts of the country participated in this seminar in which renowned experts presented papers on major issues in pharmaceutical policy. A four-page resolution (Kolkata Declaration) outlining various policy measures for a Rational Drug Policy in the context of globalisation was adopted. CHAI took lead in this initiative.

#### **The Right to health care campaign.**

→ JSA organized a National workshop and National public consultation on the 'Right to health care' on the 5<sup>th</sup> and 6<sup>th</sup> of September 2003 (25<sup>th</sup> anniversary of the Alma Ata 'Health for All' declaration) in Mumbai. This two-day programme has constituted the **launching point of JSA's 'Right to Health Care' campaign**. The public consultation, which was in the nature of a public hearing, was conducted in the presence of Justice Anand, Chairperson of the National Human Rights Commission (NHRC). It was attended by over 250 delegates from 16 Indian states, representing 85 different organizations, including CHAI, dedicated to health and rights based movements including rights for women, children, people affected by HIV, displaced people, people living in areas of conflict, as well as a number of academicians, health policy analysts, social and health activists and other interested citizens.

As a part of the process of establishing Health rights, a series of **Regional public hearings on Right to Health Care** were organized by National Human Rights Commission (NHRC) in collaboration with JSA in various parts of country. The Regional public hearing on health rights for the Western region of country was organised at Bhopal in July 2004, followed by the Southern region public hearing at Chennai in August 2004, the Northern region public hearing at



Lucknow in September 2004, the Eastern region hearing in Guwahati in November 2004. These major regional hearings, each attended by hundreds of delegates and with presentation of dozens of cases of denial of health care, were followed by a culminating event, the **National public hearing on Right to Health Care organised by JSA and NHRC on 16 – 17 December 2004 at New Delhi**. Subsequently a National action plan was released by the NHRC with inputs from JSA, towards operationalising the right to health care within the Indian context.

### **People's Rural Health Watch**

JSA started an activity to monitor and influence the National Rural Health Mission in a pro-people direction, in the form of a '**People's Rural Health Watch**'. A National level consultation was organised by JSA in May 2005, to plan the broad outline of this Watch of which CHAI was a part. Besides monitoring the actual implementation at state level, available documents regarding NRHM including task group recommendations, funding sources and financial allocations etc. was to be analysed, and an NRHM Action Alert is being compiled.

3. What has been the **contribution** of your organisation/network to JSA? (mention all the contributions including participating in national events / initiatives and contributing reports / publications / educational materials / advocacy materials / research reports / representing JSA in other regional / national / international events / contribution to governance etc.,)

1. CHAI in collaboration with JSA National Secretariat organized the People's Health Assembly-II from 23<sup>rd</sup> – 25<sup>th</sup> March 2007 at Bhopal, Madhya Pradesh
2. JSA- AP Assembly - Vijayawada, 28 & 29<sup>th</sup> April 2007, Venue: Mantissari College.
3. CHAI being a part of NCC and its Director Fr Sebastian being the State Convener, regular meeting of the state partner organizations were regularly organized under the chairmanship of Fr Sebastian.

4. From your organizational / network experience what do you think have been the main **strengths** in relationships / experience with JSA?

5. From your organizational / network experience what do you think have been the main **weaknesses** / obstacles in relationship / experience with JSA? Any suggestions of how they could have been overcome / should be overcome?

6. What **opportunities** do you see for your organisation and the JSA for collaborative functioning in the coming period?

- a) Work towards addressing the health services delivery related issues and taking it up with government.
- b) Advocating for strengthening the Health insurance sector for poor with availability of services and transparency in implementation.
- c) Strengthening the role of Nurses and giving due recognition to their roles and responsibilities. Task-shifting wherever possible.

7. Are there any observations / suggestions that could mention as problems / **challenges** that could continue to affect JSA's efforts to strengthen itself?

8. Does your organization / network have members that work with JSA at the state level - if so which states?

9. Are there any issues your organisation has encountered in getting involved in state level activities?

10. Are there any other possibilities / **opportunities** of collaborative **initiatives** / collaborative **campaigning** that can be taken forward by JSA and your organisation? Give examples?

11. Any other matter about JSA – national and state level and above NCC which you would like to raise as part of the PANS exercise?

12. List out as much of the following to supplement the information at the secretariat level. (**You may use separate sheet if required:**

- a. List of key organizations / networks in the state coordination committee as of 1<sup>st</sup> October 2011 (include list of office bearers and committees if any)
- b. List of events in the last two years - 2010 / 2011 (including engagement / dialogue with state government, campaigns, struggles, community action etc)
- c. List of publications in the last decade – 2001 – 2011 (of significance to JSA)
- d. List of translations in the state vernacular of international PHM / national JSA documents and publications
- e. List of key individuals who have represented your organizations / networks in JSA / NCC since 2001
- f. Any other information / publication / campaign materials that you would like to send to the PANS committee / secretariat

Name of respondent from organization / network  
(to be contacted by PANS committee for  
further information if required

Mr Sundar Bunga

Date: 17/10/11

9849995600

[sundar-bunga@chai-india.org](mailto:sundar-bunga@chai-india.org)

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## Participatory Assessment and Network Strengthening (PANS)

The Jan Swasthya Abhiyan has completed 10 years of working as a broad platform for co-ordinating activities in the health sector. The experience of working as JSA in the last 10 years needs to be assessed, in order to strengthen JSA as a platform of health activities and to make JSA more effective.

Keeping this in mind the National Co-ordination Committee of the JSA has decided to start a process called: Participatory Assessment and Network Strengthening (PANS). The purpose of this exercise is to, on one hand, assess our strengths and weaknesses as a network, and on the other, to draw lessons from this assessment to strengthen the network.

The self assessment that is being proposed is entirely voluntary and would be done through the participation of all those who have been associated with JSA – in the past or in the present. It should include organisations as well as concerned individuals who have shown an interest in participating in the activities of JSA.

This process is to be done in the states and the national level.

In the states the process is to have the following components:

- 1) Compute a list of all organisations and individuals who have in some way been associated with the JSA or would have interest in being associated with JSA. It should, thus, also include those who have been part of JSA earlier but have not been active in the recent period. It should also include those who have not been active in the JSA, but who we believe can be partners in the activities of the JSA.
- 2) Circulate a questionnaire (attached at the end – you can modify it based on your own requirements) to all those who are listed as JSA partners or potential partners.
- 3) Collect the responses (remember in many cases people will need to be followed up by personal contacts, so that they feel encouraged to respond to the questionnaire!) and prepare a small report.
- 4) Discuss the report in a state level meeting of the JSA (you are encouraged to invite someone from the national co-ordination committee of JSA for this meeting). Try to ensure that the meeting has the broadest possible participation from all those who would be interested in being part of JSA.
- 5) Also discuss what the state JSA's opinion is about the organisational structure of the national JSA and how it can be improved.
- 6) Based on discussions, prepare a work plan for the future. The work plan should include a plan of activities as well as a plan for organizational strengthening.

Please note that this process is to be done in states which have an active JSA, as well as in states where the JSA has not been very active. In the latter case this is an opportunity to revive the activities of JSA.

## Questionnaire

### 1) Participation in activities of JSA

Which activities of JSA, co-ordinated at the national level, have you been associated with (you can add your comments of the role you played in these activities).

a) Pre-National Health Assembly 1 (held in Kolkata in December 2000) activities in 2000

→ 110 KSSP Activists participated. Shared experiences and presented papers in different sessions.

Conducted a project called "Women empowerment through health" in 5 Districts. Poster exhibition in different places. Conducted

b) National Health Assembly 1 in Kolkata in 2000

500 classes about People's health

110 Activists participated. Shared experiences. Presented papers in different sessions.

c) Right to Health Public Hearings (Jan Sunwai) in 2004-2005

A lot of Corner meetings done,

d) NRHM watch in 2007-2008

To change the core strategy according to Kerala scenario. Conducted a Campaign at state, District & Area levels, Given a critical appraisal to the Govt.

e) Pre-National Health Assembly 2 (held in Bhopal in March 2007) activities in 2007

Started a Campaign for a Kerala Public Health Act.

Signature Campaign against Patent laws; Corner meetings.

Thousands of classes, leaflet distribution.

f) National Health Assembly 2 in Bhopal in March 2000

30 Activists including Drama team, shared experiences, presented papers.

Any other (including state JSA programmes), please list: Kerala Health minister's participation

Signature Campaign against closure of Vaccine Companies

Corner meetings, classes, leaflet campaigns done.

Formed a Peoples Health Commission under the Chairmanship of Dr. P. K. Warrier.



## 2) Experience of participating in JSA activities

Please write a few lines of the experience (positive or negative) of participating in activities of the JSA, including suggestions about how the activities could be better organised.

These are self energising or motivating activities and a feeling of unity.

Most of the JSA national conferences are like festivals. It could be better if conducted like CME about specific issues and subjects. And serious discussion on issues. Limited participants. (2)

## 3) Organisational Structure and co-ordination in JSA

Give your opinion about the organizational structure and co-ordination within JSA in your state at present. Discuss how it can be improved and strengthened.

In Kerala most of the organisations in JSA are small groups except KSSP and Christian organisation. Co-ordination is poor. Participation in meetings also poor.

Now we are planning see the member organisations individually.

## 4) Activities of your organisation in the health sector

List activities of your organisation (or as individual) in the health sector – this includes activities beyond those co-ordinated by the JSA

Last 4 yrs.

(a) KSSP :- Each year we conducted state level workshops 2-3 days for health staff in the state. ~ 150-300 participation.

And District level. (100-150) 1-2 days workshops each yr.

Started a campaign against NCD. Conducted street dramas, corner meetings, about 6000 classes about NCD (courtyard classes), poster exhibitions, NCD clinics. Leaflet & Notice campaign.

## 5) Activities of your organisation in relation to NRHM

Has your organisation been associated in any programmes of the NRHM? Discuss from the list below or add if there are any others:

a) Community Monitoring

b) Training of ASHA

Participated as resource persons only.

c) Formation of Village Health and Sanitation Committees

d) Any others (list and discuss)

We prepared a critical appraisal, according to Kerala Seniors and given to Govt.

7) Future activities of JSA

List the activities, in your opinion, that can be a priority for the state JSA and the national JSA.

1) Regular meeting and frequent communication is needed.  
Co-ordinated programs.  
Health related studies on Policy issues.  
National level discussion and state level implementation.

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KSSP. Thrissur. Kerala

drkrkrishnan@gmail.com.



(21)  
Penulis materi on  
Maharashtra.

**Jan Aarogya Abhiyan**  
**Pune, Maharashtra**

**Participants' Introduction**

1. **Anant Phadke-**
2. **Kajol-MASUM** work on health MP-JSA, monthly meetings Jan Sunwai Barwani, study of health services. Participated in MP Right to Health events, MASUM-long association with JSA
3. **Ankita-MASUM** 1 year BAMS Gynaecology Specialization  
Rigna Hakka Parishad-Pune  
MASUM survey presentation at national level especially on women's health issues, charter, drafts  
Anupama was the representative into JSA.
4. **Ranjana Kanhere**, Jan Sunwai Saswad Shramik Sangathan earlier. Originated 12 years ago. 2002 associated with JSA M. Jan Sunwais, Community Base Monitoring (CBM) (Nandurbar). Now organization works on health issues – MH and CBM in Nandurbar District. Sickle Cell Anaemia brought this issue to JSA. State level initiative but others in District involved. Home based neonatal care also, most work on health, Forest Protection in 5 villages, Right to Food Campaign also.
5. **Suhas-NBA, NAPM**. Ravi Narayan came to an NAPM meeting before Calcutta Assembly. Participated at national level with Binayak. After 2<sup>nd</sup> Assembly decided to drop out-NAPM not represented heeded at national level.  
Not just NBA, part of a larger network JSA, useful link. CBM in NBA villages. Now participate more in Pune, Maharashtra activities.
6. **Trupti-SATHI** 2007, JAA meetings attended earlier also. After joining SATHI more involved.
7. **Medha Golve-Samata** Pratishthan since 2000 active participation-Santosh.
8. **Shubhangi Kulkarni-Beed** Dist. Went to Cal, Dacca also from her organization, cut practice, malpractice. People take loans for health. Micro finance work, federation, credit cooperative. Health Mutual Fund (interest free loans), Anaemia shibirs, Hysterectomies  
NRHM participation  
Street play on alcoholism.

2000 Jan Sunwai. For 7-8 years not part of JAA because of Micro Finance. After NRHM, CBM selection at block level. Now Judaav.

9. **Sneha** (Anand's organisation)-Samayak, DV community based work on poor women
10. **Manjusha Shinde**-Lok Pratishthan Sanstha, Osmanabad, 2000 PHA Calcutta Malnutrition survey  
NHRC Denial case, in Jan Sunwai  
2004-05 Lok Sabha elections yatra. Smita participated 2004 Latin Marathwada Jan Sunwai organized by them. Right to Health Care (RtHC) campaign. Savings groups-health awareness pregnant women
11. CBM 2 districts
12. **Jayashree Gaikwad**-Child Health, Jan Sunwais Pune District, CBM  
Konde Sir-Convenor Pune JAA
13. **Shantha Ranade**-National Federation  
JAA and Right to Food Campaign consistent, Senior activist
14. **Abhay**
15. **Abhijit**-Pts Right
- 16.

**Suhas**-Please include me when national level discussions happen. Please include all those who dropped out.

**Abhay**-Not everyone in national level is healthy. Not everyone agreed to the need of the review. It was a struggle.

**Renu**-Our responsibility therefore greater-inclusiveness, transparency, accountability etc.

**Kajol**-Gave an account of the Pune meeting.

**Anant**-read Mumbai report. Representation from 10 organizations.

1. **Suhaas**-Charter is a guiding document, to become a member. Are all issues relevant today?  
Which aspects of Charter have each of us worked on?  
Each member can decide what issue to work on depending on their own expertise and context.  
Worked on rural because space available-NRHM, Urban space not available.  
Perspective: Water groups joined in Determinants of health. The force of Calcutta-Dhaka was a magnet.



**Shantha**-Charter is a long term guiding document. NGOs work on individual issues. Now NGOs members, they take one issue, not a holistic approach. All sangathans cannot work on policy matters-e.g. Drug policy.

As JSA we have to take a position, not as individual sangathans.

**Ranjana**-How to disseminate the charter to get more membership? Get in groups working on health but not a part of JAA.

Mental Health should be included in JAA's work at policy level-state level also no work on mental health. District level advocacy done for a weekly OPD for MH, so much need for JAA to exert pressure at state level. More beds required for MH in the state.

**Kajol**-Charter has MH issue. How can JAA use the charter for issues? Organizations working on this issues, but is it JAA agenda???

State JSA representatives took the MH issue to the national level (e.g. PHC) and accepted there.

**Shantha**-MH organizations came (Bapu Trust) but did not continue.

**Suhas**-Process needs to take charter to people. Generation change, need to keep charter alive.

**Abhay**-Charter vision document, not plan of action. Consensus building document.

2000 Health system crisis, so people came out as a response. We did not strategize enough, and make a concrete plan to match members, responsibilities and charter contents. This was a gap. Also who can be possible stake holders-savings groups, panchayat leaders etc. - we did not think about this enough.

'Taking charter to people'-it has to be made understandable. Material based on the charter not created.

**Kajol**-Taking charter to people without planning/strategy, what's the point? We need to decide at state level.

**Abhay**-Women's health and tribal health incorporated into Rural Health memorandum with Dr.Salunke, overlap present. Documentation of denial of right to health, influenced by women's health constituency.

**Jayashree**-Instead of more people joining, members are decreasing. Student's etc. signature campaign etc. done but no explanation given on what is this network? Should spread awareness we are working mainly with NGOs and Sangathans.

JAA should go to village level. We do village work as our own organizations, not as JAA.

**Beed**-Local activist and state/policy activist relationship should be reciprocal.

Domestic violence and MH and economic affordability all linked. We should work with a holistic perspective.

I don't know what the charter contains, haven't read it. Was a volunteer at age of 18. Now a full time staff. Charter needs to go to people.

CBM work. When it will close, who knows what will happen? Through JAA we should do CBM. Poor areas, services not available.

**Ankita**-Organizations focus on their own issues for community work. JAA activists we should have the commitments to disseminate the charter in our field areas.

**Shailesh**-Issues to be identified.

**Kajol**-It is clear that members of JAA want to work-need to decide what will be the campaign? Charter can be taken ahead, through a campaign.

we do not interact with local communities only with Field level organizers of NGOs/sangathanas.

We need a Local body of JAA activists, not restricted to organization and Sangathan.

**Anant**-Charter is not a vision document but a programme document also. Each of 20 issues is very important for people's health movement in India.

In JAA in the state, Occupational Health not taken in. Drug Policy is a national issue, patent issue is a national issue.

#### **Decisions taken collectively after discussions in meetings:**

Sub committees were there-Women's Health, Occupational Health, Herbal Medicines, Tribal Health, e.g. of Tribal Health and Women's Health. Ranjana-Cells formed, but could not continue because of work overload. Tribal cell had very dispersed members, so did not work out, should be District or Regional level JAA, perhaps not issue based.

#### **Nagpur and Gadchiroli-Satish Gogulwar**

- Supported meetings with money from other projects. Funding stopped, meetings stopped.
- Right to Food campaign active.

Meetings are/were regular, 2/year, correspondence okay, dialogue, but no follow up.



5-6 years regular meetings, since last 2 years planned meetings not happening. Now piggy backing meetings. Mostly along with CBM.

Thematic meetings: 30<sup>th</sup> October, National Health Bill discussion meeting

Review meetings required, in different places e.g. Osmanabad, now in Mumbai and Pune.

April 6<sup>th</sup> JSA review linked to CBM workshop.

#### Suggestions:

- Meetings should be on reporting, problems, issues, 6 monthly planning
- Decentralized meetings
- Half with CBM and not with CBM half
- 1/year organizational reviews
- Inclusion-people not coming.  
Need to revive, find newer groups from local levels
- Trupti-regional meetings should be strengthened
- Abhay-SATHI did JAA's coordination earlier. Now and in future, 3 organizations-CEHAT, BGVS, Tathapi Regional Coordinators

2004-05-State level meeting coordination has come on SATHI. Regional coordinators not that functional.

Now MASUM, Ami AAmcha Arogya Sathi and SATHI-coordinators.

Collective coordination required Suhas calls.

Need for dialogue with all first-on what issues? In regions.

Issues from National Secr. Taken up by JAA

- NHA II Bhopal: State Health Assembly
- Boycott Novartis – (nonstarter)
- Patients rights
- Right to Health Care Campaign: Bhopal Public Hearings 2004-07
- Urban Health Mission (Mumbai-to national)
- National Health Act
- 4<sup>th</sup> Nov Delhi
- Anand Grover meeting
- Election manifesto-People's Front

Fairly okay response

When national secretariat in Pune, greater interaction. After secre. Shifted to Bhopal, don't know what is happening at national level. After what happened in Bhopal regarding Nandigram, Suhas said that she withdrew.

PHA NCC not much happening these days.

Hyderabad July 2000 meetings should have been with wider participation

**Any suggestions given from state to national?**

Urban Health issue

NHRC-put sector public hearings

Pts' rights-but nothing happened.

September 2003-Justice Anand, NHRC

Want to know what is the process of deciding national issues? What is the process decided at national level for national to state relationship and vice versa?

Lateral relationships-between state JSAs should also be recognized e.g. Gujarat and Maharashtra on the Gujarat Public Health Act etc.

Need to share more between states. Share resources, exchange visits.

**Relationship between National JSA and Government?**

Abhay relates

**CBM and JSA?**

Nandurbar-Difference in committee formation before and after CBM.

Advantages and Disadvantages

Sarpanches corrupt others, ANM and Sarpanch shared the spoils. Committee had to be monitored vis-à-vis untied funds CBM-PHC improved, District and State level issues same.

Pts rights from SATHI, but not JAA banner.



Drs. Accountability has not increased due to Jan Sunwais. Doctors Association resists-we will not tolerate this. Zilla Parishad also resists. People's awareness 'It is our right to ask questions? Time bound programme of CBM, does not leave time for being JAA activist.

**Jayashree**-Earlier also there were VHSCs, now we've activated them. Now there is an opposition/a space to raise issues.

We have to coordinate with health officials-carrot and stick.

CBM samajh bani, we can use in JAA.

Now we know more what happens at PHC, CHC levels positive results of CBM-lab tech recruitment, drug availability increased. But PHC upgrading not happened, which we can take up in JAA.

**Manjusha**-Medicines increased in PHC. Diarrhoea less because preventive measures. ANM-MPW improved. CHC no improvement. Can fight equally because CBM will be closed, there is JAA behind me if we fight too much (at political level) organization given in writing bring CBM here because support from village people. Greater work satisfaction.

(Better resources perhaps from state?)

Ta meeting, we will solve your problems here, don't take to the health department. Local level think 'we have great power'.

District level not yet improved.

**Ankita**-Masum JSA should take space apart from CBM.

**Suhas**-RACHNA Trust, Janarth, too much time in CBM, Health work reduced to CBM in 5 project villages. Not wider application.

**Anant**-Programmatically CBM has gone ahead-Accountability, change in power relations etc. But JAA as an organization has been negatively affected because limitation of time and energy. Depth (in accountability etc.) but narrowing of JAA agenda.

**Tripti**-Many issues we will not be able to resolve through CBM. If JAA's organizational capacity is so weak then how can we take up major emerging issues? Need to assess efforts v/s. outputs. Project will go on in only defined districts-What about dissemination to other districts? Systematic issues will have to be addressed by JAA. We have left behind so many active members. Need to balance.





Dear Ravi, PANS team and friends,

Apologies for the delay in sending my comments to you earlier. Perhaps Ravi and Venkatesh might have finalized his presentation but still if there is time to incorporate any of my suggestions I request Ravi to do so or share it in the meeting during the PANS review process.

I have attended the JSA Orissa PANS meeting in Bhubaneswar in October. There were nearly 20 members from various organisations from Bhubaneswar and other neighbouring districts participated. I wanted to share my observations and comments within my brief interaction.

1. I cannot call the Orissa chapter inactive as there is a lot of interest from the groups who have attended the meeting to carry forward JSA in the state. JSA Orissa appeared to be broad based and includes other networks like NAWO etc. Efforts towards this have been made by the state coordinator, Gourango Mohapatro.
2. JSA Orissa has also evolved an interesting strategy to sustain JSA activities which is very important to acknowledge. JSA Orissa has been associated with various campaigns in the state, with important studies/surveys related NRHM, Budget tracking and other related activities trainings/workshops on issues related to gender, displacement, mining, flood, technologies, maternal deaths, conflict, etc. JSA Orissa has also carried out a few fact findings, which has brought up violations particularly in the context of Kandhamal, etc. These regular activities has kept JSA Orissa alive and substantiated its relevance.
3. There was a discussion on support to the State coordinator. In one of the participant's words "*we have a committed driver and a vehicle but there is no petrol*". They did explain that petrol means both human resources, and information. Since Gaurango is also working with BGVS, to run JSA independently he requires more human resources. The group came up with a suggestion that they should start a membership fee and the meetings can be held in other partner groups office spaces. This is to strengthen the involvement of others.
4. There was also a suggestion to rotate the Secretariat every couple of years.

#### Acknowledging the strengths, I would also like to comment on certain gaps.

There is a need to involve more women and women's groups and women participants in JSA. Women's groups role should not be limited to issues such as violence, maternal deaths, etc. They can also get engaged in other JSA activities related to NRHM etc.

There is a need to build the capacities of partner groups. Some are still limited to health is hygiene and sanitation appraoch. There is a need to build the capacity on larger determinants of health.

There is a need to build second level leadership within the JSA Orissa.

Many of the activities that JSA Orissa has been involved in the recent past are initiatives by diverse organisations and networks. While this has contributed to sustained activities and campaigns by JSA Orissa, it would also be useful (organizationally) to explore how the decisions / initiatives by JSA Orissa are prioritized and operationalised, given this context.

#### The Orissa PANS meeting

It was repeatedly expressed that the states require regular inputs by senior activists, joint convenors on specific issues.

Capacity building

Regular communications with other states and national level organizers

Campaign strategies

Expanding the resource base

The issues which we may not take up at national level like conflict, natural disasters like floods (which is a major issue in Orissa); JSA should include these in the future planning.

Since there is no coordinated activity with the national level and lack of communication, their level of activism gets invisibilised. Even if they issue any statement in the media as JSA, it never gets reflected in the national media. Since there is no reporting, sharing taking place with others, we (who are outside the state) might get a feeling that there is nothing happening. We should also understand the limitations with technology. Not every state is equipped rather has the privilege to circulate/share their actions/activities through internet exchanges. Hence, we need to establish a mechanism where and how this aspect of communication get resolved. We also need to rethink about the role of National Convenor and the Joint Convenors if they are not actively contributing to the State processess.

Lastly, I would like to acknowledge Gourango, Usha and other friends from various networks, Organisations who participated in the meeting and contributed to the discussion. I have also forwarded the suggestions from Jagannath Chatterjee who was also at the meeting.

Best wishes

[Sarojini]

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Home » Charters & Declarations » The People's Charter for Health

## The People's Charter for Health

Date:

Jan 2009

The People's Charter for Health is a statement of the shared vision, goals, principles and calls for action that unite all the members of the PHM coalition. It is most widely endorsed consensus document on health since the Alma Ata Declaration.

The People's Health Charter was formulated and endorsed by the participants of the First People's Health Assembly held at Dhaka, Bangladesh in December 2000.

In 1978, at the Alma-Ata Conference, ministers from 134 countries in association with WHO and UNICEF called for 'Health for All by the Year 2000' and selected Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of Third World populations has not improved. In many cases it has deteriorated further. Currently, we are facing a global health crisis, characterised by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalisation which prevent the equitable distribution of resources necessary for people's health, particularly the poor.

Within the health sector, failure to implement the principles of primary health care as set out in the Alma-Ata Declaration, has significantly aggravated the global health crisis. Governments and the international community are fully responsible for this failure.

It is now essential to build a concerted international effort to put the goal of Health for All in its rightful place in the development agenda. Genuine, people-centred initiatives must be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organisations and civil society movements, non-governmental organisations (NGOs) and women's groups decided to work together towards this objective. This group, together with others committed to the principles of primary health care and people's perspectives organised the People's Health Assembly, which took place from 4-8 December 2000 in Bangladesh, at Savar, on the campus of Gonoshasthaya Kendra (GK - People's Health Centre).

453 participants from 92 countries came to Assembly which was the culmination of 18 months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.

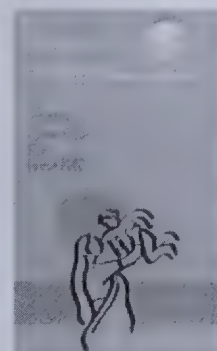
At the Assembly, they reviewed their problems and difficulties, shared their experiences and plans, and formulated and endorsed the People's Charter for Health. The Charter is now the common tool of a worldwide citizen's movement committed to making the Alma-Ata dream a reality. We encourage and invite everyone who shares our concerns and aims to join us by endorsing the Charter.

**Help us to disseminate the charter!**

**Make a translation!** Please get in touch with Pam Zinkin and PHM secretariat to check if a translation in your

<http://phm.org/en/resources/charters/peopleshealth>

### Translations of the charter



- Arabic
- Bangla
- Chinese
- Danish
- Dutch
- English
- Farsi
- Filipino
- Finnish
- French
- German
- Greek
- Guarani
- Hausa
- Hindi
- Indonesian
- Italian
- Japanese
- Kannada
- Korean
- Malayalam
- Ndebele
- Nepalese
- Portuguese
- Quichua
- Russian
- Serbian
- Sérère
- Sinhala
- Spanish
- Swahili
- Swedish
- Thai
- Turkish
- Ukrainian
- Urdu
- Wolof
- Yoruba





# People's Health Movement



People's  
Charter  
For  
Health







## INTRODUCTION

In 1978, at the Alma-Ata Conference, ministers from 134 member countries in association with WHO and UNICEF declared "Health for All by the Year 2000" selecting Primary Health Care as the best tool to achieve it.

Unfortunately, that dream never came true. The health status of third world populations has not improved. In many cases it has deteriorated further. Currently we are facing a global health crisis, characterized by growing inequalities within and between countries. New threats to health are continually emerging. This is compounded by negative forces of globalization which prevent the equitable distribution of resources with regard to the health of people and especially that of the poor.

Within the health sector, failure to implement the principles of primary health care, as originally conceived in Alma-Ata has significantly aggravated the global health crisis.

Governments and the international bodies are fully responsible for this failure.

It has now become essential to build up a concerted international effort to put the goals of health for all to its rightful place on the development agenda. Genuine, people-centered initiatives must therefore be strengthened in order to increase pressure on decision-makers, governments and the private sector to ensure that the vision of Alma-Ata becomes a reality.

Several international organizations and civil society movements, NGOs and women's groups decided to work together towards this objective. This group together with others committed to the principles of primary health care and people's perspectives organized the "People's Health Assembly" which took place from 4-8 December 2000 in Bangladesh, at Savar, on the campus of the Gonoshasthasthaya Kendra or GK (Peoples Health Centre).

1453 participants from 92 countries came to the Assembly which was the culmination of eighteen months of preparatory action around the globe. The preparatory process elicited unprecedented enthusiasm and participation of a broad cross section of people who have been involved in thousands of village meetings, district level workshops and national gatherings.





The plenary sessions at the Assembly covered five main themes: Health, Life and Well-Being; Inequality, Poverty and Health; Health Care and Health Services; Environment and Survival; and The Ways Forward. People from all over the world presented testimonies of deprivation and service failure as well as those of successful people's initiatives and organization. Over a hundred concurrent sessions made it possible for participants to share and discuss in greater detail different aspects of the major themes and give voice to their specific experiences and concerns. The five days event gave participants the space to express themselves in their own idiom. They put forward the failures of their respective governments and international organizations and decided to fight together so that health and equitable development become top priorities in the policy makers agendas at the local, national and international levels.

Having reviewed their problems and difficulties and shared their experiences, they have formulated and finally endorsed the People's Charter for Health. The charter from now on will be the common tool of a worldwide citizens' movement committed to make the Alma-Ata dream reality.

We encourage and invite everyone who shares our concerns and aims to join us by endorsing the charter.

## PREAMBLE

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed. This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations.

## VISION

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the





flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that shape our lives. There are more than enough resources to achieve this vision.

## THE HEALTH CRISIS

*"Illness and death every day anger us. Not because there are people who get sick or because there are people who die. We are angry because many illnesses and deaths have their roots in the economic and social policies that are imposed on us"*

*(A voice from Central America)*

In recent decades, economic changes world-wide have profoundly affected people's health and their access to health care and other social services.

Despite unprecedented levels of wealth in the world, poverty and hunger are increasing. The gap between rich and poor nations has widened, as have inequalities within countries, between social classes, between men and women and between young and old.

A large proportion of the world's population still lacks access to food, education, safe drinking water, sanitation, shelter, land and its resources, employment and health care services. Discrimination continues to prevail. It affects both the occurrence of disease and access to health care.

The planet's natural resources are being depleted at an alarming rate. The resulting degradation of the environment threatens everyone's health, especially the health of the poor. There has been an upsurge of new conflicts while weapons of mass destruction still pose a grave threat.

The world's resources are increasingly concentrated in the hands of a few who strive to maximise their private profit. Neoliberal political and economic policies are made by a small group of powerful governments, and by international institutions such as the World Bank, the International Monetary Fund and the World Trade Organisation. These policies, together with the unregulated activities of transnational corporations, have had severe effects on the lives and livelihoods, health and well-being of people in both North and South.





Public services are not fulfilling people's needs, not least because they have deteriorated as a result of cuts in governments' social budgets. Health services have become less accessible, more unevenly distributed and more inappropriate.

Privatisation threatens to undermine access to health care still further and to compromise the essential principle of equity. The persistence of preventable ill health, the resurgence of diseases such as tuberculosis and malaria, and the emergence and spread of new diseases such as HIV/AIDS are a stark reminder of our world's lack of commitment to principles of equity and justice.

## PRINCIPLES OF THE PEOPLE'S CHARTER FOR HEALTH

- The attainment of the highest possible level of health and well-being is a fundamental human right, regardless of a person's colour, ethnic background, religion, gender, age, abilities, sexual orientation or class.
- The principles of universal, comprehensive Primary Health Care (PHC), envisioned in the 1978 Alma Ata Declaration, should be the basis for formulating policies related to health. Now more than ever an equitable, participatory and intersectoral approach to health and health care is needed.
- Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay.
- The participation of people and people's organisations is essential to the formulation, implementation and evaluation of all health and social policies and programmes.
- Health is primarily determined by the political, economic, social and physical environment and should, along with equity and sustainable development, be a top priority in local, national and international policy-making.





## A CALL FOR ACTION

To combat the global health crisis, we need to take action at all levels - individual, community, national, regional and global - and in all sectors. The demands presented below provide a basis for action.

## HEALTH AS A HUMAN RIGHT

Health is a reflection of a society's commitment to equity and justice. Health and human rights should prevail over economic and political concerns.

*This Charter calls on people of the world to:*

- Support all attempts to implement the right to health.
- Demand that governments and international organisations reformulate, implement and enforce policies and practices which respect the right to health.
- Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation.
- Fight the exploitation of people's health needs for purposes of profit.

## TACKLING THE BROADER DETERMINANTS OF HEALTH

### Economic challenges

The economy has a profound influence on people's health. Economic policies that prioritise equity, health and social well-being can improve the health of the people as well as the economy.

Political, financial, agricultural and industrial policies which respond primarily to capitalist needs, imposed by national governments and international organisations, alienate people from their lives and livelihoods. The processes of economic globalisation and liberalisation have increased inequalities between and within nations. Many countries of the world and especially the most powerful ones are using their resources, including economic sanctions and military interventions, to consolidate and expand their positions, with devastating effects on people's lives.





*This Charter calls on people of the world to:*

- Demand transformation of the World Trade Organisation and the global trading system so that it ceases to violate social, environmental, economic and health rights of people and begins to discriminate positively in favour of countries of the South. In order to protect public health, such transformation must include intellectual property regimes such as patents and the Trade Related aspects of Intellectual Property Rights (TRIPS) agreement.
- Demand the cancellation of Third World debt.
- Demand radical transformation of the World Bank and International Monetary Fund so that these institutions reflect and actively promote the rights and interests of developing countries.
- Demand effective regulation to ensure that TNCs do not have negative effects on people's health, exploit their workforce, degrade the environment or impinge on national sovereignty.
- Ensure that governments implement agricultural policies attuned to people's needs and not to the demands of the market, thereby guaranteeing food security and equitable access to food.
- Demand that national governments act to protect public health rights in intellectual property laws.
- Demand the control and taxation of speculative international capital flows.
- Insist that all economic policies be subject to health, equity, gender and environmental impact assessments and include enforceable regulatory measures to ensure compliance.
- Challenge growth-centred economic theories and replace them with alternatives that create humane and sustainable societies. Economic theories should recognise environmental constraints, the fundamental importance of equity and health, and the contribution of unpaid labour, especially the unrecognised work of women.

### **Social and political challenges**

Comprehensive social policies have positive effects on people's lives and livelihoods. Economic globalisation and privatisation have profoundly disrupted communities, families and cultures.





Women are essential to sustaining the social fabric of societies everywhere, yet their basic needs are often ignored or denied, and their rights and persons violated.

Public institutions have been undermined and weakened. Many of their responsibilities have been transferred to the private sector, particularly corporations, or to other national and international institutions, which are rarely accountable to the people. Furthermore, the power of political parties and trade unions has been severely curtailed, while conservative and fundamentalist forces are on the rise. Participatory democracy in political organisations and civic structures should thrive. There is an urgent need to foster and ensure transparency and accountability.

*This Charter calls on people of the world to:*

- Demand and support the development and implementation of comprehensive social policies with full participation of people.
- Ensure that all women and all men have equal rights to work, livelihoods, to freedom of expression, to political participation, to exercise religious choice, to education and to freedom from violence.
- Pressure governments to introduce and enforce legislation to protect and promote the physical, mental and spiritual health and human rights of marginalised groups.
- Demand that education and health are placed at the top of the political agenda. This calls for free and compulsory quality education for all children and adults, particularly girl children and women, and for quality early childhood education and care.
- Demand that the activities of public institutions, such as child care services, food distribution systems, and housing provisions, benefit the health of individuals and communities.
- Condemn and seek the reversal of any policies, which result in the forced displacement of people from their lands, homes or jobs.
- Oppose fundamentalist forces that threaten the rights and liberties of individuals, particularly the lives of women, children and minorities.
- Oppose sex tourism and the global traffic of women and children.





## Environmental challenges

Water and air pollution, rapid climate change, ozone layer depletion, nuclear energy and waste, toxic chemicals and pesticides, loss of biodiversity, deforestation and soil erosion have far-reaching effects on people's health. The root causes of this destruction include the unsustainable exploitation of natural resources, the absence of a long-term holistic vision, the spread of individualistic and profit-maximising behaviours, and over-consumption by the rich. This destruction must be confronted and reversed immediately and effectively.

*This Charter calls on people of the world to:*

- Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health.
- Demand that all development projects be evaluated against health and environmental criteria and that caution and restraint be applied whenever technologies or policies pose potential threats to health and the environment (the precautionary principle).
- Demand that governments rapidly commit themselves to reductions of greenhouse gases from their own territories far stricter than those set out in the international climate change agreement, without resorting to hazardous or inappropriate technologies and practices.
- Oppose the shifting of hazardous industries and toxic and radioactive waste to poorer countries and marginalised communities and encourage solutions that minimise waste production.
- Reduce over-consumption and non-sustainable lifestyles - both in the North and the South. Pressure wealthy industrialised countries to reduce their consumption and pollution by 90 per cent.
- Demand measures to ensure occupational health and safety, including worker-centred monitoring of working conditions.
- Demand measures to prevent accidents and injuries in the workplace, the community and in homes.
- Reject patents on life and oppose bio-piracy of traditional and indigenous knowledge and resources.





- Develop people-centred, community-based indicators of environmental and social progress, and to press for the development and adoption of regular audits that measure environmental degradation and the health status of the population.

### **War, violence, conflict and natural disasters**

War, violence, conflict and natural disasters devastate communities and destroy human dignity. They have a severe impact on the physical and mental health of their members, especially women and children. Increased arms procurement and an aggressive and corrupt international arms trade undermine social, political and economic stability and the allocation of resources to the social sector.

*This Charter calls on people of the world to:*

- Support campaigns and movements for peace and disarmament.
- Support campaigns against aggression, and the research, production, testing and use of weapons of mass destruction and other arms, including all types of landmines.
- Support people's initiatives to achieve a just and lasting peace, especially in countries with experiences of civil war and genocide.
- Condemn the use of child soldiers, and the abuse and rape, torture and killing of women and children.
- Demand the end of occupation as one of the most destructive tools to human dignity.
- Oppose the militarisation of humanitarian relief interventions.
- Demand the radical transformation of the UN Security Council so that it functions democratically.
- Demand that the United Nations and individual states end all kinds of sanctions used as an instrument of aggression which can damage the health of civilian populations.
- Encourage independent, people-based initiatives to declare neighbourhoods, communities and cities areas of peace and zones free of weapons.





- Support actions and campaigns for the prevention and reduction of aggressive and violent behaviour, especially in men, and the fostering of peaceful coexistence.
- Support actions and campaigns for the prevention of natural disasters and the reduction of subsequent human suffering.

## A PEOPLE-CENTERED HEALTH SECTOR

This Charter calls for the provision of universal and comprehensive primary health care, irrespective of people's ability to pay. Health services must be democratic and accountable with sufficient resources to achieve this.

*This Charter calls on people of the world to:*

- Oppose international and national policies that privatise health care and turn it into a commodity.
- Demand that governments promote, finance and provide comprehensive Primary Health Care as the most effective way of addressing health problems and organising public health services so as to ensure free and universal access.
- Pressure governments to adopt, implement and enforce national health and drugs policies.
- Demand that governments oppose the privatisation of public health services and ensure effective regulation of the private medical sector, including charitable and NGO medical services.
- Demand a radical transformation of the World Health Organization (WHO) so that it responds to health challenges in a manner which benefits the poor, avoids vertical approaches, ensures intersectoral work, involves people's organisations in the World Health Assembly, and ensures independence from corporate interests.
- Promote, support and engage in actions that encourage people's power and control in decision-making in health at all levels, including patient and consumer rights.
- Support, recognise and promote traditional and holistic healing systems and practitioners and their integration into Primary Health Care.
- Demand changes in the training of health personnel so that they become more problem-oriented and practice-based, understand better the impact of global issues in





their communities, and are encouraged to work with and respect the community and its diversities.

- Demystify medical and health technologies (including medicines) and demand that they be subordinated to the health needs of the people.
- Demand that research in health, including genetic research and the development of medicines and reproductive technologies, is carried out in a participatory, needs-based manner by accountable institutions. It should be people- and public health-oriented, respecting universal ethical principles.
- Support people's rights to reproductive and sexual self-determination and oppose all coercive measures in population and family planning policies. This support includes the right to the full range of safe and effective methods of fertility regulation.

## PEOPLE'S PARTICIPATION FOR A HEALTHY WORLD

Strong people's organisations and movements are fundamental to more democratic, transparent and accountable decision-making processes. It is essential that people's civil, political, economic, social and cultural rights are ensured. While governments have the primary responsibility for promoting a more equitable approach to health and human rights, a wide range of civil society groups and movements, and the media have an important role to play in ensuring people's power and control in policy development and in the monitoring of its implementation.

*This Charter calls on people of the world to:*

- Build and strengthen people's organisations to create a basis for analysis and action.
- Promote, support and engage in actions that encourage people's involvement in decision-making in public services at all levels.
- Demand that people's organisations be represented in local, national and international fora that are relevant to health.
- Support local initiatives towards participatory democracy through the establishment of people-centred solidarity networks across the world.





AMENDMENT

After the endorsement of the PCH on December 8, 2000, it was called to the attention of the drafting group that action points number 1 and 2 under Economic Challenges could be interpreted as supporting the social clause proposed by the WTO, which actually serves to strengthen the WTO and its neoliberal agenda. Given that this countervails the PHA demands for change of the WTO and the global trading system, the two paragraphs were merged and amended.

The section of War, Violence and Conflict has been amended to include natural disasters. A new action point, number 5 in this version, was added to demand the end of occupation. Furthermore, action point number 7, now number 8, was amended to read to end all kinds of sanctions. An additional action point number 11 was added concerning natural disasters.

The People's Health Assembly and the Charter

The idea of a People's Health Assembly (PHA) has been discussed for more than a decade. In 1998 a number of organisations launched the PHA process and started to plan a large international Assembly meeting, held in Bangladesh at the end of 2000. A range of pre- and post-Assembly activities were initiated including regional workshops, the collection of people's health-related stories and the drafting of a People's Charter for Health. The present Charter builds upon the views of citizens and people's organisations from around the world, and was first approved and opened for endorsement at the Assembly meeting in Savar, Bangladesh, in December 2000. The Charter is an expression of our common concerns, our vision of a better and healthier world, and of our calls for radical action. It is a tool for advocacy and a rallying point around which a global health moment can gather and other networks and coalitions can be formed.

Join Us - Endorse the Charter

We call upon all individuals and organisations to join this global movement and invite you to endorse and help implement the People's Charter for Health.

PHM Global Secretariat  
Email: [secretariat@phmovement.org](mailto:secretariat@phmovement.org)  
Web: [www.phmovement.org](http://www.phmovement.org)





Endorse  
the People's  
Charter for Health

Personal information

Name

First: .....

Last: .....

Mailing Address

Street and No.: .....

City: .....

State: .....

Zip Code: .....

Country: .....

Email: .....

Organization

Name: .....

Website: .....

Comments on the Charter

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## Any Suggestions for the PHM?

Don't be hesitated to add any further suggestions in separate papers.





# People's Health Charter

We the people of India, stand united in our condemnation of an iniquitous global system that, under the garb of 'Globalisation' seeks to heap unprecedented misery and destitution on the overwhelming majority of the people on this globe. This system has systematically ravaged the economies of poor nations in order to extract profits that nurture a handful of powerful nations and corporations. The poor, across the globe, as well as the sections of poor in the rich nations, are being further marginalised as they are displaced from home and hearth and alienated from their sources of livelihood as a result of the forces unleashed by this system. Standing in firm opposition to such a system we reaffirm our inalienable right to and demand for comprehensive health care that includes food security; sustainable livelihood options including secure employment opportunities; access to housing, drinking water and sanitation; and appropriate medical care for all; in sum - the right to **Health For All, Now!**

The promises made to us by the international community in the Alma Ata declaration have been systematically repudiated by the World Bank, the IMF, the WTO and its predecessors, the World Health Organization, and by a government that functions under the dictates of International Finance Capital. The forces 'Globalisation' through measures such as the structural adjustment programme are targeting our resources - built up with our labour, sweat and lives over the last fifty years - and placing them in the service of the global "market" for extraction of super-profits. The benefits of the public sector health care institutions, the public distribution system and other infrastructure - such as they were - have been taken away from us. It is the ultimate irony that we are now blamed for our plight, with the argument that it is our numbers and our propensity to multiply that is responsible for our poverty and deprivation. We declare health as a justiciable right and demand the provision of comprehensive health care as a fundamental constitutional right of every one of us. We assert our right to take control of our health in our own hands and for this the right to:

- A truly decentralized system of local governance vested with adequate power and responsibilities, provided with adequate finances and responsibility for local level planning.
- A sustainable system of agriculture based on the principle of *land to the tiller* - both men and women - equitable distribution of land and water, linked to a decentralized public distribution system that ensures that no one goes hungry
- Universal access to education, adequate and safe drinking water, and housing and sanitation facilities
- A dignified and sustainable livelihood
- A clean and sustainable environment

- A drug industry geared to producing epidemiological essential drugs at affordable cost
- A health care system which is gender sensitive and responsive to the people's needs and whose control is vested in people's hands and not based on market defined concept of health care.

Further, we declare our firm opposition to:

- Agricultural policies attuned to the needs of the 'market' that ignore disaggregated and equitable access to food
- Destruction of our means to livelihood and appropriation, for private profit, of our natural resource bases and appropriation of bio-diversity.
- The conversion of Health to the mere provision of medical facilities and care that are technology intensive, expensive, and accessible to a select few
- The retreat, by the government, from the principle of providing free medical care, through reduction of public sector expenditure on medical care and introduction of user fees in public sector medical institutions, that place an unacceptable burden on the poor
- The corporatization and commercialization of medical care, state subsidies to the corporate sector in medical care, and corporate sector health insurance
- Coercive population control and promotion of hazardous contraceptive technology which are directed primarily at the poor and women
- The use of patent regimes to steal our traditional knowledge and to put medical technology and drugs beyond our reach
- Institutionalization of divisive and oppressive forces in society, such as communalism, caste, patriarchy, and the attendant violence, which have destroyed our peace and fragmented our solidarity.

In the light of the above we demand that:

1. The concept of comprehensive primary health care, as envisioned in the Alma Ata Declaration should form the fundamental basis for formulation of all policies related to health care. The trend towards fragmentation of health delivery programmes through conduct of a number of vertical programmes should be reversed. National health programmes be integrated within the Primary Health Care system with decentralized planning, decision-making and implementation with the active participation of the community. Focus be shifted from bio-medical and individual based measures to social, ecological and community based measures.





- Recommend repeal of the new patent act and bring back mechanisms that prevent creation of monopolies and promote introduction of new drugs at affordable prices
- Promotion of the public sector in production of drugs and medical supplies, moving towards complete self-reliance in these areas.

8. Medical Research priorities be based on morbidity and mortality profile of the country, and details regarding the direction, intent and focus of all research programmes be made entirely transparent. Adequate government funding be provided for such programmes. Ethical guidelines for research involving human subjects be drawn up and implemented after an open public debate. No further experimentation, involving human subjects, be allowed without a proper and legally tenable informed consent and appropriate legal protection. Failure to do so to be punishable by law. All unethical research, especially in the area of contraceptive research, be stopped forthwith. Women (and men) who, without their consent and knowledge, have been subjected to experimentation, especially with hazardous contraceptive technologies to be traced forthwith and appropriately compensated. Exemplary damages to be awarded against the institutions (public and private sector) involved in such anti-people, unethical and illegal practices in the past.

9. All coercive measures including incentives and disincentives for limiting family size be abolished. The right of families and women within families in determining the number of children they want should be recognized. Concurrently, access to safe and affordable contraceptive measures be ensured which provides people, especially women, the ability to make an informed choice. All long-term, invasive, systemic hazardous contraceptive technologies such as the injectables (NET-EN, Depo-Provera, etc.), sub-dermal implants (Norplant) and anti fertility vaccines should be banned from both the public and private sector. Urgent measure be initiated to shift to onus of contraception away from women and ensure at least equal emphasis on men's responsibility for contraception. Facilities for safe abortions be provided right from the primary health center level.

10. Support be provided to traditional healing systems, including local and home-based healing traditions, for systematic research and community based evaluation with a view to developing the knowledge base and use of these systems along with modern medicine as part of a holistic healing perspective.

11. Promotion of transparency and decentralization in the decision making process, related to health care, at all levels as well as adherence to the principle of right to

information. Changes in health policies to be made only after mandatory wider scientific public debate.

12. Introduction of ecological and social measures to check resurgence of communicable diseases. Such measures should include:

- Integration of health impact assessment into all development projects
- Decentralized and effective surveillance and compulsory notification of prevalent diseases like malaria, TB by all health care providers, including private practitioners
- Reorientation of measures to check STDs/AIDS through universal sex education, promoting responsible safe sex practices, questioning forced disruption and displacement and the culture of commodification of sex, generating public awareness to remove stigma and universal availability of preventive and curative services, and special attention to empowering women and availability of gender sensitive services in this regard.

13. Facilities for early detection and treatment of non-communicable diseases like diabetes, cancers, heart diseases, etc. to be available to all at appropriate levels of medical care.

14. Women-centered health initiatives that include:

- Awareness generation for social change on issues of gender and health, triple work burden, gender discrimination in upbringing and life conditions within and outside the family; preventive and curative measures to deal with health consequences of women's work and violence against women
- Complete maternity benefits and child care facilities to be provided in all occupations employing women, be they in the organized or unorganized sector
- Special support structures that focus on single, deserted, widowed women and minority women which will include religious, ethnic and women with a different sexual orientation and commercial sex workers; gender sensitive services to deal with all the health problems of women including reproductive health, maternal health, abortion, and infertility
- Vigorous public campaign accompanied by legal and administrative action against sex selective abortions including female feticide, infanticide and sex pre-selection.

15. Child centered health initiatives that include:





- A comprehensive child rights code, adequate budgetary allocation for universalisation of child care services
- An expanded & revitalized ICDS programme. Ensuring adequate support to working women to facilitate child care, especially breast feeding
- Comprehensive measures to prevent child abuse, sexual abuse and child prostitution
- Educational, economic and legal measures to eradicate child labour, accompanied by measures to ensure free and compulsory quality elementary education for all children.

16. Special measures relating to occupational and environmental health which focus on:

- Banning of hazardous technologies in industry and agriculture
- Worker centered monitoring of working conditions with the onus of ensuring a safe and secure workplace on the management
- Reorienting medical services for early detection of occupational disease
- Special measures to reduce the likelihood of accidents and injuries in different settings, such as traffic accidents, industrial accidents, agricultural injuries, etc.

17. The approach to mental health problems should take into account the social structure in India which makes certain sections like women more vulnerable to mental health problems. Mental Health Measures that promote a shift away from a bio-medical model towards a holistic model of mental health. Community support & community based management of mental health problems be promoted. Services for early detection & integrated management of mental health problems be integrated with Primary Health Care and the rights of the mentally ill and the mentally challenged persons to be safe guarded.

18. Measures to promote the health of the elderly by ensuring economic security, opportunities for appropriate employment, sensitive health care facilities and, when necessary, shelter for the elderly. Services that cater to the special needs of people in transit, the homeless, migratory workers and temporary settlement dwellers.

19. Measures to promote the health of physically and mentally disadvantaged by focussing on the abilities rather than deficiencies. Promotion of measures to integrate them in the community with special support rather than segregating them; ensuring equitable opportunities for education, employment and special health care including rehabilitative measures.

20. Effective restriction on industries that promote addictions and an unhealthy lifestyle, like tobacco, alcohol, pan masala etc., starting with an immediate ban on advertising, sponsorship and sale of their products to the young, and provision of services for de-addiction.





## Appendix 10

### People's Health Movement, India: Jan Swasthya Abhiyan (JSA)

#### Evolution of the JSA

"India witnessed the largest mobilisation, spread across almost 30,000 villages. More than 2000 organizations participated in this countrywide mobilization in about 300 districts in 20 states. 18 National Networks jointly led the campaign. This was the first time the country witnessed the coming together of so many diverse organizations and movements. Based on village and primary health center level enquiries, many districts drew up local health priorities, which were fed, into district convention and state conventions.

The final culmination of this nationwide process was the National Health Assembly (NHA-I) held in Kolkata on 1st December 2000. More than 2300 delegates from all parts of the country traveled to Kolkata for the National Health Assembly in five People's Health Trains. The National Health Assembly declared the major goals of the Indian People's Health Movement and demarcated the specific issues on which the People's Health Movement in India would concentrate. It adopted a 20-point charter known as the Indian Peoples' Health Charter, outlining a critical analysis of the Indian health scenario in the context of globalization. This charter provides a statement of the shared understanding and goals that unite all the organizations working as part of this network of networks. The assembly culminated in a 30,000 strong rally followed by a public meeting".<sup>1</sup>

*The group that came together prior to the PHA, was broad – they were organizations and networks from across the political spectrum. That health for all had not come to India perhaps motivated them along with the realization that the larger global – political scenario regardless of what sector or work one was doing was impacted by some commonalities. There was probably a recognition of multiple issues, reflected in JSA's charter, and discovering that health is all of these.*

The national networks and organizations that had come together to organize the National Health Assembly, at the time only focused on the assembly. They then decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (the Indian chapter of the People's Health Movement).

Some of the states within India had a long history of people's struggles and movements around social issues. This, according to some, also determined / facilitated the growth and functioning of the JSA in some states.

#### Jan Swasthya Abhiyan: Perspective and Objectives

The Jan Swasthya Abhiyan believes that despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people

<sup>1</sup> PHM India Report





worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

The JSA is of the opinion that these trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation – all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis. These deficiencies include:

- A retreat from the goal of comprehensive national health and drug policies as part of overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.
- A failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services.
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a human right.

The major objectives of the Jan Swasthya Abhiyan are as below:

1. The Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the policies of iniquitous globalisation on the health of Indian people, especially on the health of the poor.
2. The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. The JSA seeks a renewal of this commitment, with the slogan 'Health for All - Now!'. The JSA locates the campaign to achieve this in the campaign to establish the Right to Health and Health Care as basic human rights. The JSA also believes that Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
3. The thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care.
4. Top down, bureaucratic, fragmented techno-centric approaches to health care lead to considerable wastage of scarce resources and fail to impact significantly on the health situation. The Jan Swasthya Abhiyan feels that there is an urgent need to promote decentralisation of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands".





5. The Jan Swasthya Abhiyan seeks to network with all those interested in promoting peoples' health. It seeks to initiate and promote a wide variety of people's initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems.<sup>2</sup>

## Structure



The JSA national organizers group comprises of a national convenor and eight joint convenors. The joint convenors were earlier from specific geographical regions and expected to lead and coordinate mobilization and initiatives in their respective regions. Each state has its own coordination group and structure. Some states have further decentralized structures - created for improved co-ordination and for better outreach to different regions within the state, towards focus / prioritization of issues, coordination, mobilization. However, the state level JSA in many states is inactive and requires rejuvenation. Further, the need to expand JSA within the states – mobilize participation of many more organisations and networks is critical.

The national organizers group includes women and men – currently 3 and 5 (six men including the national convenor) respectively.

Some of the roles of the convenors' group is to facilitate democratic processes, to follow up, build consensus and conflict resolution.

Lack of rotation of convenors was perceived as a drawback and prevented wider participation and new leadership. The structure of the NCC and the processes for membership at the state level need to be reviewed.

*In JSA we definitely need a rotational process. For e.g., the convenor has been the same for 10 years. The secretariat has been rotating but there are issues of lack of coordination. .... now it is completely dormant.*

Leadership and governance were perceived as critical elements for JSA, especially at present where both are considered to be weak or inactive. This situation was not perceived as because of the lack of potential leaders or their willingness to play this role, rather as a result of no concerted action on this front. One respondent felt that this was, in general, unwilling to reflect on organizational issues.

The JSA's National Coordination Committee (NCC) consists of representatives of member organizations responsible for planning and coordination. At present the JSA NCC comprises 22 national level organizations and networks.

The discussions highlighted concerns about the present structure at the national level; does it lend itself to expansion, growth? There was lack of clarity about the rigidity of the 22 organisations / networks. State level PHM activists expressed that such a structure excludes organisations that are active in the people's health movement at the state level. Networks and

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<sup>2</sup> PHM India Report





organisations that are part of the 22 NCC members are also not necessarily active at the state level. The national structure therefore is not a whole / complete reflected of the mobilization of organisations and issues in different states of the country.

What if the groups that are actually active want to become part of the PHM, gain recognition – is there a process for formal recognition? Why are some organisations / networks “recognized” and others not. Should states have their state level letterheads or some such things that can provide visibility and formal recognition.

### Coordination within JSA ★

Coordination at the national level is carried out by a national secretariat, housed in an organisation, led by a national coordinator. Similarly each state also has a coordinator. The responsibility of national and state level coordination is rotated. The national and state coordinators and secretariats play a crucial role in flagging issues, facilitating Interlinkages between PHM organisations/activists, dissemination of information, mobilization, coordinate meetings, etc.

The need to improve coordination within the state and also across states, as well as at the national level in India, was expressed by nearly by all those who were interviewed. At present the governance, coordination structures were far from active, was a concern expressed by many. Coordination of JSA had seen some rough times in the past, but the present time was perceived as the most inactive period for JSA.

Given the spread of the country and in keeping with the goal of expansion, wider mobilization and responding to the myriad health issues, a strong national / central coordination was seen as extremely important.

A few respondents said that national level coordination, from past experience, had clearly shown the need for dedicated persons involved in coordination.

*JSA has huge potential. It is a group of peers not “one person led”. In that way, it is different from other networks. It has also made the second line of leadership possible. There have really not been any issues of keeping anyone down. It has promoted leadership, skills (albeit in a limited way). It is a growing movement.*

All respondents reinforced the significance of the people’s health movement at the national, regional and global levels particularly in the current global eco- political context. Therefore the need for revival of the JSA, which as one activist described is “paralysed but not dead” and a more coordinated functioning by the PHM were urgently required. There is also need for the national coordination group to play the role of conflict resolution between organisations and networks that may impact the working of the JSA in a state. ★

### JSA identity: Movement or Network 1. ?

The perceptions about PHM’s identity – whether a movement or network - were varied. While some respondents were very clear about the PHM being a network / a “network of networks”, one activist described it as a “campaign for a movement”, and some others felt that it was a network with the goal towards building a movement for people’s health.





A disjunct and paradox exists in the PHM. The nomenclature and understanding of a people's health movement rests on people's involvement / movement for health, to achieve their health rights. However, responses highlighted the implications of the understanding of the identity. For example, the nature of engagement as a network and as a movement, according to some, would differ. Governance, decision making structures of JSA, as they exist, are more akin to a network than a movement. The identity would also have implications for funding – whether or not to receive funds, to what extent, for what activities / aspects should funding be sourced, etc. As one activist expressed,

*I personally feel that it is not a movement right now. They (some JSA activists) say that it is a network of networks and hence does not confront (the state). .....confrontation is not a PHM method. Voices against are not acceptable? But a movement is not only "health is political" but to "politically see health". There is no political strategy.*

Another reason for not perceiving the JSA as movement was the limited involvement of grassroots people, organisations at the local level.

*There is limited reflection of lack of mobilization at the grassroots even at the global level. Sustained multi-centric mobilisation, especially at the grassroots level is missing. The steering committee members may also in some ways be a reflection of this – not rooted in people's health movements.*

#### Profile of organisations associated with JSA

*[only organisations with high profile...?]*

The profile of organizations associated with JSA is diverse. A complete /compiled list of all organizations, who are part of JSA does not exist yet. JSA comprises people's movements, indigenous / adivasi movements to academic institutions, women's organizations, organizations working on disability rights, mental health, food security, etc. across diverse political ideologies. However, not all organizations working on these issues have a national presence and vice versa – i.e., not all organizations at the national level are active in the states. This has raised some concerns about "the need for recognition of organisations who are part of JSA". There is need to put in place some mechanism for this at the state and national levels.

*Groups want to be part of JSA. How do they become part of it? How will a new adivasi group become part of it. There is no clarity about this. Do groups have to approach the governance at the national level or the coordination unit or group at the state level? Some of the national networks that are part of JSA are not necessarily part of the state JSA. Here they were dysfunctional but we cannot remove them from the letterhead, for example, and include other groups. How do groups that are actually active become part of it; gain recognition?*

#### Mobilising participation in JSA

Mobilising continues to be a major challenge for the JSA. The lack of mobilization is seen as one of the biggest gaps within JSA. While this is well recognized, proactive action to address this need to be urgently initiated. Mobilisation has to be multipronged. It has to extend to newer





geographical areas / states where JSA is not active presently; within areas and states where JSA has a presence and is active, there is need to reach out to others – organisations and groups working on health and other issues. There is particular need to mobilize organisations and networks working with dalits, adivasis, LGBTQI..., working on issues of disability and mental health. It is also important to involve organisations that are working on health issues but are currently not part of JSA.

*There is a very big gap in community mobilization. The second National Health Assembly that took place in March 2007 provided a great opportunity for expansion. It witnessed a wide mobilization of groups organisations and networks working with the marginalized and on diverse health issues. However, we just let it slide and did not follow up sufficiently.*

With regard to mobilization, one of the greatest challenges is to sustain the active involvement of groups at the state and national levels. Strategies need to be deliberated, sharing of positive experiences in this regard from the states and even other countries where PHM is active would be useful. Strengthening a collective, common understanding of PHM / JSA's understanding of health may be the first step in this direction.

*There are differences in groups – e.g. disability or mental health want to focus on their issues, not perceiving that unless primary health care is available to all, these will also not get resolved.*

*Another drawback is – for example, sexual minority groups – only when someone gets affected then they raise the issue or are actively involved. But they should be part of the movement even otherwise. It is a challenge to sustain collective effort.*

While not all organisations and groups may be active in all campaigns and initiatives by the JSA, it is a challenge to expand their engagement so that 'other' issues and campaigns (issues that they may not be engaged with directly) also gain their support and solidarity.

challenge

## JSA Activities / Campaign areas

### Areas of Interest and Themes



Jan Swasthya Abhiyan has within its wide range of members, a large number of resource persons, and activities in a number of thematic areas. The important areas are listed below:

- Policy level interventions for Right to Health and Health Care
- Primary Health Care and health systems that can provide access to health care services for the poor and the marginalised
- Community Health Worker Programmes and Community Based Monitoring of Health services
- Women's Health issues and Reproductive health rights
- Child Health and Malnutrition






- Right to Food and investigation of hunger related deaths
- Violence & Women's Health
- Sex determination and sex selective abortions
- WTO, Intellectual property rights, patents and Drug policy
- Medical Professional Reform and Regulation of medical practice
- Privatisation of health services and the commercialisation of health care
- Health care in conflict situations
- Indigenous Medicine and Folk healing traditions
- Rational Drugs and Diagnostics
- Drinking Water, Sanitation, Environment & Health
- Health among Displaced people, Adivasis and other marginalized sections
- Population control programme and issues of Contraceptive choice
- Trends in Medical and Vaccine Research
- Control of Communicable Disease
- Mental Health issues
- Human Resource Development for Health Care
- Tobacco Control for better health



### **Major Co-ordinated Campaigns of the JSA**

The participating organisations and networks in the JSA have their own independent activities. In addition, the JSA co-ordinates national or regional campaigns/activities that involve all or a major section of its constituents. Some of the major campaigns initiated and co-ordinated by the JSA are as follows:

 **People's Rural Health Watch (PRHW):** The idea of a People's Rural Health Watch was conceived of by JSA following its Right to Healthcare Campaign, and after the launch of the NRHM. From the public hearings during the Right to Healthcare Campaign, it became evident that the problems were more systemic rather than simply isolated cases of denial of healthcare by some health functionaries. Given the objectives of the NRHM to improve rural health services, PRHW was viewed as a way of looking at the performance of the rural public health system, and of analyzing and assessing the issues arising out of its implementation. It would be an activity to document and assess what were the areas that were getting more attention in the implementation process, whether or not people were getting better health services with the introduction and implementation of NRHM, and provide some feedback for improvement.

This was to be done by collecting primary information through periodic surveys, as well as by looking at relevant policy documents, and preparing reports based on all this information. These reports were to be widely disseminated and discussed, and would also be the basis for mobilization and action at the local level. The information collected was to be also used to support monitoring of health services by civil society organizations, and to watch for and check possible negative developments in the context of the mission.

The PRHW activity was planned as a two-year activity, between January 2006-2008. The final Report of this activity is now ready and brings together and analyses the information collected over 2006-2008, from surveys carried out in some high-focus states and from policy documents and published reports. The Report is based on data received from MP, UP, Bihar, Rajasthan, Jharkhand and Chhattisgarh.







**Right to Health Care Campaign:** A nationwide campaign by Jan Swasthya Abhiyan to establish the Right to Health Care as a basic human right for every citizen in India. As part of this campaign Public Hearing on Denial of Health Care have been organised all over India in collaboration with the National Human Rights Commission.

**Campaign against Sex Selective Abortions:** In response to the Public Interest Litigation regarding Pre Natal Diagnostic Tests and Sex Selective Abortions filed in Supreme Court, JSA initiated a campaign related to constitution of appropriate authorities, registration of ultrasound centers, ban on advertisements, displaying posters in clinics and the issue of son preference. This campaign was taken up intensively in a number of states especially in Tamil Nadu, Haryana and Himachal Pradesh in the second half of 2001.

**Hunger Watch:** Jan Swasthya Abhiyan has set up a 'Hunger Watch' group consisting of public health and nutrition experts to provide assistance to the Right to Food Campaign. A JSA 'Hunger Watch' group has prepared a protocol to investigate cases of hunger-related or starvation deaths.

**Involvement in the Right to Food Campaign:** In several states, surveys have been conducted by JSA constituents on the status of mid-day meal and other schemes. In several states, a convention on 'Right to food - Right to health' have been organised. A resource material package in the form of a book "If even one person goes hungry..." was brought out by Tamil Nadu Science Forum and Bharat Gyan Vigyan Samiti for the Right to Food campaign and it has served to inform the public and keep the issue alive. There is a growing focus on 'Children's Right to Food' and Jan Swasthya Abhiyan has played a key role in the development of this campaign and issue within the overall campaign for the Right to Food.

**Civil Society Facilitation in the Asian Region for the Commission on Social Determinants of Health:** JSA has been identified as one of the two organisations in the Asian regions to facilitate civil society participation in the Commission on Social Determinants of Health, constituted by the WHO. Towards this end JSA has helped convened meetings in 10 countries of the region. JSA is in the process of facilitating Civil Society inputs into the Commission's final report.

**National Health Assembly II:** In March 2007 the JSA organised a three day National Health Assembly in Bhopal, that brought together over 400 organisations and over 2000 participants from across the country. For three days the participants discussed and debated on several thematic areas. The Assembly also saw the participation of about a hundred foreign delegates, who participated in a special session that focused on global concerns on Health. The Assembly also discussed the thrust of future activities for JSA, which are detailed later.

### ***Interventions by the JSA in major issues related to Public Health***

In addition to the major campaigns described above, JSA has intervened in several national policy issues and processes. Some of the key ones are listed below:

**National Rural Health Mission:** The National Rural Health Mission aims to fulfill the United Progressive Government's commitment to meet people's aspirations for better health and access to health care. The JSA is, however, of the opinion that the Mission must move beyond





populist policy rhetoric and become part of a bold paradigm shift, from providing services through top down planning to building capacity and empowering communities to manage their own health care needs. The JSA is engaged in impacting on the development of the Mission's perspective and plan of action through dialogues with policy makers, participation in the Mission's Task Forces, and mobilisation of its constituents.

**TRIPS and the Indian Patent Amendment Act:** The TRIPS agreement required India to change to a Product Patent regime in the area of pharmaceuticals and food, from the earlier system provided in the Amendment of the Indian Patents Act of 1970 which did not provide for Product Patents in these areas. Such a move has many negative implications on people's ability to access essential medicines. The JSA has been an active partner in the campaign to pressure the government to make full use of the safeguards available in the TRIPS agreement to safeguard Public Health.

**Initiatives related to Drug Policy:** The JSA has been active in pursuing the development of a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines and of national self-reliance. The National Policy on Pharmaceuticals was discussed when it was in the draft stage and a JSA critique was evolved which was widely shared. JSA participated in a public campaign concerning the Pharmaceutical Policy, that was initiated by one of its constituent organisations – the Federation of Medical Representatives Association of India (FMRAI). Many states have held discussions regarding an essential drug policy and to build public awareness on the impact of globalisation on the pharmaceutical sector. In a well attended convention on 5<sup>th</sup> December 2007, the JSA adopted a charter of demands of the Government and also formulated a plain for future activities. Prominent among these is a call issued by JSA to Boycott products manufactured and sold by the Swiss MNC, Novartis, in protest against its continued efforts to stop local production of its vital anti-cancer drug called Gleevec.

**Pre-Election Dialogue with Political Parties :** Prior to the elections in April 2004, and in May 2009, Jan Swasthya Abhiyan initiated a dialogue with political parties to encourage them to focus on the real concerns of the Indian people especially political initiatives in health care - most important of which was making health a fundamental right and increasing the budgetary allocation for public health. A discussion with the political parties along with the panelists was organised in Delhi followed by a rally demanding "Right to Health Care". Prior to these meetings a pamphlet and policy brief was circulated to the political parties addressing the various issues concerned.

## **Women's Health**

Following are some of the major activities related to Women's Health that the JSA proposes to pursue as part of its activities:

- Campaign to ensure that justice is done for Bhopal survivors, ensure access to various determinants of health – water, food, livelihoods and access to health services and compensation.
- Campaign to abolish coercive population policies – to revoke the 2 child norm.
- Campaigns on issues of mental health, focus on disability (physical and mental),





issues and concerns of sexual minorities.

- Campaign against violence against women – violence within home; state violence eg. Gujarat Carnage, including policies programs which violate women's rights (girl children and adolescent girls); or cause / exacerbate violence against women.
- Campaign on women's, girl children and adolescent girls nutrition. This would require long term follow up and monitoring of nutritional status
- Campaign to implement Supreme Court order on sterilisations; ensure compensation in case of failures / violations. Also ensure conditions / quality of care so that failures are prevented. March 3<sup>rd</sup> every year could be designated for this campaign as the SC order was made on this day.
- Campaign towards ensuring implementation of PCPNDT Act. There is a PCPNDT advisory committee, which JSA should try and be a part of.
- Laws and acts related to women should be monitored and ensure their implementation. e.g. Domestic violence bill.
- Campaign to ensure care for women and prevent violations in institutions including institutions for mental health. Public hearings could be organized to document experiences of women in public institutions, towards advocacy.

### ***Medicines Policy***

Following are some of the activities proposed, related to the drug industry and policies relating to the manufacture, sale, prescription and use of medicines:

- Campaign Committees be formed in all States.
- Campaign for revitalisation of the public sector and observe a day when a nationwide call would be given to promote this campaign.
- Deputations to meet state drug controllers for regulation of prices and weeding out of irrational medicines.
- Consider filing a Public Interest Litigation and/or initiate other measures for weeding out of irrational medicines.
- A campaign booklet shall be prepared listing the areas of concern, to take forward the campaign.
- Organise Public hearing on medicine prices and irrational medicines.
- Discussion with the concerned Ministries to be sought for pursuing the above demands.
- Launch a wide campaign against unethical business practices and unethical promotion by drug companies, and follow up with the filing of specific complaints to relevant agencies against such practices.
- Campaign among the medical students and medical practitioners on issues related to rational use of drugs.
- Promote and intensify the Boycott Novartis Campaign among medical professionals till Novartis ceases its challenge against the rejection of its Patent application on Gleevec.

### ***Child Health***





JSA shall work with the Right to Food campaign in advocating policy options that address child malnutrition, including, for example, the expansion of the ICDS scheme. Other interventions to be promoted include a critical analysis of policies promoting food fortification with nutrients and micro-nutrients.<sup>3</sup>

Other activities in the recent past also include the IPHU's Health and Equity Course at Bangalore, India organized in association with the People's Health Movement, Jan Swasthya Abhiyan, Community Health Cell (SOCHARA) and Prayas (Rajasthan) on 1-9 September, 2009 at Bangalore.

### **Publications**

Publications by JSA include:

- The People's Charter for Health
- The National Health Assembly Booklets series (7 nos)
  - Booklet 1- Globalisation and Health
  - Booklet 2 – Health System in India
  - Booklet 3 – Women's Health
  - Booklet 4 – Campaign Issues in child health
  - Booklet 5 – New Technologies in Public Health
  - Booklet 6 – HIV AIDS Treatment Access
  - Booklet 7 – Access to Essential Medicines
  - Booklet 8 – (Draft) Towards a people's alternative health plan

Apart from these draft booklets were also developed on social exclusion, issues with the elderly, etc.

- People's Health Manifesto (2009)
- People's Rural Health Watch Report

In addition, JSA has also drafted policy briefs, memorandums, review papers, etc. Most of the publications mentioned here are efforts at the national level, there are also several states who have developed publications, articles, fliers, posters in the local languages. While some of these are uploaded on the JSA website, a comprehensive repository of all the materials, especially from the states would be extremely useful and is a recommendation that has emerged from the evaluation process.

### **Communication within JSA and between JSA and regional /global PHM**

Overall, the responses reflected that the communication within JSA was at an "all time low". While ensuring that communication reaches out the maximum number of organisations and networks, wide dissemination of information and maximum involvement has always been challenging, communication was perceived at the national level to be near absent in the past 1-1 ½ years.

Communication among convenors and coordinators, the national coordination (NCC) takes place through emails. It forms the primary mode of regular communication and is limited at the

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<sup>3</sup> PHM India Report





national level to those who are part of the NCC. Apart from this, meetings at the state level as well as at the national level also facilitate communication – planning, review of strategies, campaigns and initiatives.

★ Regarding global communication, i.e. communication from global PHM to JSA and vice versa was seen as restricted to a very few people. Therefore, most respondents stated that they were not aware of any of the happenings at the global level. Communication about regional or global PHM process are shared at times by some, but there is no systematic / regular feedback by those who are part of global processes and initiatives. This was also expressed in the context of the present evaluation – respondents expressed that there should have been wider / prior communication about the evaluation.]

## Regional PHM

Almost all respondents claimed ignorance about PHM in the region. Most of them were unaware of who the regional coordinator was as also the regional structures. The need for a stronger regional coordination and regional exchange of information was expressed. A dedicated person for regional coordination was suggested towards based on the Africa experience. Resources for regional coordination were also identified as a need.

★ India is perceived as a separate region, which most respondents were not aware of. However, those who were aware, felt that India should be part of South Asia, regardless of its size.

*We need to prioritise funding for movement building. Right now maximum money goes into IPHU. There is very little money for right to health care and other aspects.*

## Gender and Marginalised

While gender is mainstreamed in publications, articles, etc., it was felt that gender perspectives continue to be insignificant. At the global level, while some of the initiatives like CSDH addressed gender, at the national and state levels, there is very little engagement with groups, organisations that have a strong gender perspective. JSA has made attempts, for example, the Indian Women's Health Charter was disseminated at the national assembly, but these are ad hoc. A strategy should be developed for engendering perspectives, campaigns, etc. as well as for ensuring inclusion.

*There may be inclusion of gender / gendered understanding of issues but this needs to be strengthened. For example on the issue of drugs gendered concerns need to be highlighted. Discussion on gender within the PHM, needs to grow. It needs to be part of our decision making process.*

JSA was perceived as a male domain and "exclusive". In some ways JSA reproduced the structure of society.





In JSA, dalit involvement has been limited to health assembly largely. This was also perceived with regard to other marginalisations. Largely the 'dominant paradigm' was seen to prevail – whether in governance structures, participation, etc.

## Funding

The national secretariat of the JSA has received funding in the past. While the process to source funds by the current secretariat was initiated, no funding support has come through so far. Most of the respondents stated that funding was important to coordinate, towards wider mobilization. At the state level, it was not possible to gain information in this regard in the process of the evaluation. In one of the states, the organisation who is coordinating the JSA, had included the costs within their overall organizational proposal / budget.

*Funding never affected the character of JSA. We didn't take funding just for funding. We were very mindful of the "money not dictating". That level of caution needs to be maintained. There has to be a strong will to manipulate to our advantage.*

## At the regional / global level

Most respondents were not aware of funding sources of PHM at the global level nor the activities or campaigns for which they were received / sought. Of those who were aware, one activist said,

*There is urgent need for funding for global programmes. We need to channelize funding for movement building. There is very little money and if it has to be distributed widely then the amount available to each is very little. We need to be strategic and use money for processes that lend to getting people to come together.*

## Achievements

- Responses about achievements highlighted the many activities, campaigns and issues that JSA has been engaging with in the past decade.
- JSA is highly visible. Members of JSA are invitation by the government regularly to be part of committees to plan, review health programmes and policy. However, one of the activists also expressed that most often, there was no information on who from JSA had been invited and sometimes identities – of organizations are put prior because they are not in a position to represent JSA as there is no clear position or because there has been no collective deliberation.
- In some of the states where JSA is active, it is seen as an important actor in facilitating change.
- JSA is perceived as a very important entity that needs to be strengthened and must play a significant future role.

## Challenges and Recommendations





- JSA is usually unwilling to review organizational issues and processes. A review process was planned last year but there has been no move forward on that front.
- If the movement needs to be strengthened then we need a national vision, multicentric mobilization on key issues. Wider mobilization of different sectors – trade unionists, nurses / health providers who are sympathetic and agree with JSA principles, etc. is critical.
- Steering committee needs to communicate proactively, clarity about the roles, composition of the PHM SC is also necessary. The process is not very systematic and transparent right now. If there is a country representative in the SC, clarity / transparency about the process followed for selection, participation of JSA governing structures in selection process and regular feedback by the representative is necessary
- JSA has played an important role so far but there should be more grounded voicing of issues – wider grassroots mobilization is a must. Does the PHM want to reach only organisations or also reach the people directly?
- The use of JSA opportunistically was also raised as a major concern. Some respondents were concerned at the non transparent nature of engagement by JSA members in PHM global and at the national levels, of processes and initiatives without the knowledge of other JSA members and activists.
- Similarly there needs to be clarity on processes prior to someone / anyone representing JSA.
- Rotation and review of those who are part of the governance structure – convenors as well as organisations.
- Accountability mechanisms need to be put in place for all who are part of these structures.
- Although JSA /PHM talks about social determinants but there is not enough support for campaigns for determinants in India.
- Review of structure at the national (JSA) as well as global PHM should be undertaken to ensure diversity and inclusion.
- To ensure that PHM principles of diversity and inclusion are followed while upholding the autonomy of a country (in the region) or state, a system of review between countries in a region or within the country (India) should be undertaken at regular intervals. This could enable interlinkages and peer pressure to ensure that principles are followed. Broad democratic principles can be provided.
- PHM is very visible in some areas – as in the WHO. There is no information about the PHM in different countries – no information and skewed view of PHM
- A record of JSA in all states as well as PHM countries, particularly in the region, their structures, activities would be very useful to create linkages and strengthen campaigns on common issues. This could be facilitated by the secretariat (JSA national and PHM global).
- National secretariat needs dedicated persons – past experiences have shown that if JSA plans national level campaigns in addition to ongoing activities for mobilization then at least two persons are required.





## Some reflections and observations on JSA/PHM from Non PHM Sources:

This compilation of reflections on and relevant to JSA-PHM at the extended JSA -NCC meeting in Nagpur on 12<sup>th</sup> November 2011, was an effort to keep all of us informed about all the different ways in which the movement is being contextualized, described, thought about and reviewed. The idea was to make us aware that JSA /PHM visibility and credibility has increased over the decade. It is however very important for us to make our own reviews, social audits, and reflections based on praxis and evidence gathered by processes such as PANS so that an overview of the movement and its strengths, weaknesses, opportunities, and challenges emerges as a learning from our own efforts and not only from what others write or surmise about us. These reflections are collated from a wide range of sources which we in SOCHARA have been keeping track of over the years. They provide a very wide range of assessments. What is significant however is that many of these descriptions of the movement now also appear in standard text books of public health in many countries helping to make young public health professionals more aware of the social movements and determinants of health. These are only extracts. The originals need to be sourced to get the full articles or paragraphs on the movement.

1. Five sources pre-PHM help us to contextualize the evolution of the movement.

a) **Health for All report 1981- The Prescription of ICMR and ICSSR**

“A Mass movement to

- Reduce Poverty inequality and spread education.
- **Organise poor and underprivileged to fight for their basic rights**
- Move away from the counter productive Western model of health care and replace it by an alternative based in the community .....

b) **An Epidemiological, Socio- cultural and political analysis and a perspective (1986) by Prof. D. Baneerji of JNU-CSMCH**

“ ....Health service development is thus

- A socio cultural process
- **A political process**
- A technology and managerial process, with epidemiological and sociological perspective”

c) **The strategy of Preventive Medicine – 1992, Prof. Geoffery Rose, LSHTM**

“ The primary determinants of disease are mainly economic and social and therefore its remedies must also be economic and social ...

**Medicine and politics cannot and should not be kept apart.”**

d) **People's Health in People's Hands, Dr. N.H. Antia, 1993**

“ This will be the single – most important aspect of this model as the whole concept of the community health care system is based on the community being involved and eventually taking responsibility for its own health care including the health services meant for their welfare.....

.....In the ultimate, the operation of the health system will be determined by the political will either to look after the basic needs of all as decided at Independence or exaggerated needs of a few”.

e) **Agenda for change presented to independent commission on health in India (1998) by CHC SOCHARA in its chapter on Human Resource Development.**

It is time to recognize the role of the community, the consumer, the patient and the people in the health policy debate .....

What is needed is a strong countervailing movement initiated by health and development professionals and activists, consumer and people's organizations that



will bring health care and medical education and their right orientation high on the political agenda of the country  
MARKET or PEOPLE ? What will be our choice?"

**2. Comments on the People's Health Resource Books (Five) in India -2000AD** which were used for JSS mobilization, by Halfdan Mahler, DG Emeritus, WHO and Architect of the Alma Ata Declaration.

"These books are the best expressions of primary health care concepts and its politics that I have ever read. They are the bible of primary health care, a glorious milestone on the tortuous road to primary health care...."

**3. Report on Globalization and Health - Berkeley University, USA, 2004**

"This movement is engaged in what amounts to 'globalization from below' as it builds support for its global 'Health For All Now' strategy, lobbies at the global level and mobilizes a grassroots based campaign to realize the vision and achieve the goals of the People's Charter for Health."

"The People's Health Movement is clear evidence that the existing linkages between globalisation and health are contestable. The People's Health Movement and the People's Charter for Health provide a significant expression of alternatives 'from below' to the present globalisation, privatisation and commercialisation of health coming 'from above.'"

Source : Richard Harris and Melinda Seid, 2004, Perceptions on Global Development and Technology, Vol-3, No.1-2, 2004, Special issue: Globalization and Health, Brill.

**4. Public Health Textbook in UK – 2005**

The Peoples Health Movement is an international network of organization and individuals that came together in 2000 to reignite the call for the Health for All, Now. The goal of PHM is to reestablish the health and equitable development as top priorities at local, national and international policy making, with comprehensive primary health care as the strategy to achieve this priorities..... It is transnational network ..... and a good example of an emerging player in global civil society... On a day today basis the secretariat in Bangalore ..... puts forward strategic campaigning priorities....

Source: Kelley Lee and Jeff Collin (Eds.) Global Change and Health, Understanding Public Health Series, LSHTM, Open University Press.

**5. Recognising the Alternative Sector- in a WHO SEARO publication in 2005**

"Many alternative institutions, both organized and informal have been actively involved in public health work, as well as public health capacity building. Sometimes they have been termed as alternative sectors.....

... A wave of community health NGO movements has taken place to try alternative experiments and actions, and to build capacity from communities and grass root workers. Unless the national apex institutions or schools of public health recognize these alternative sectors as strong resources and involve them in training and research, a large portion of creative energy in public health will remain untapped...

...For example, in India, the following organizations, among others have been active in public health education and training- some since the 1980's and others more recently:

- Network of Community Health trainers and voluntary organizations who conduct short courses in community health, development and management
- Peoples Health Movement
- Society for Community Health Awareness, Research and Action (CHC - CPHI)
- Centre for Enquiry into Health and Allied Themes (CEHAT)



The list can be enriched by examples from other countries as well as with more examples from India.

Source: South East Asia Public Health Initiative -2004-2008, Strategic Framework for Strengthening Public Health Education, SEA-HSD 282, WHO SEARO, New Delhi, 2005

#### 6. Public Health Text Book – Sweden, 2006

“A strong voice in the global health debate for free primary health care is the people’s health movement which in 2000, presented the Peoples Health Charter. The charter argues strongly for a publicly financed health services and for development policies that favours health.... This network presently led from Bangalore in India is a leading representative for NGO’s in the Global health debate. This global network is itself a new aspect of globalisation”

Source: Ann Lindstrand, Hans Rosling and others, **Global Health – An introductory text book** ([www.studentlitteratur.se](http://www.studentlitteratur.se))

#### 7. Advocacy with PAHO to renew Primary Health Care and recognize social determinants of health ( PAHO primary health care document -2007)

Recognizes the PHM role in evolving the new health and human rights approach to Primary Health Care – with the necessity of tackling the broader social and political determinants of health.

Successful PHC services, encourage (community) participation, are accountable, have appropriate level of investment to guarantee adequate services and ensure services are accessible regardless of person’s ability to pay.

Also quotes people’s charter for Health.

Source: Promoting Primary Health Care in the America’s, PAHO PHC document 2007

#### 8. Globalization of Health, 2007

“ History suggests that such changes often demand radical forms of political mobilization and action, although history has not yet encountered such a demand on a global scale. No simple precedents exists but several forms of mobilization are already been pursued.....

The simultaneous rise of a global civil society movement pressing for political actions to shift the rules of contemporary globalization

Source: Ichiro Kawachi, and Sarah Wamala (Eds), **Globalization and Health**, Oxford University Press, 2007.

#### 9. The New Public Health Paradigm (The First Text Book by a chairperson of the movement steering committee), 2008

The text book covers the following:

1. Approaches
2. Political Economy
3. Research including Qualitative evidence
4. Health Inequalities
5. Unhealthy environment
6. Healthy Societies and healthy environment
7. Health Promotion
8. Public Health in the 21st Century ( linking local , National & Global Systems)

*It is our ambition to develop a public health approach that responses to the globalised world and respond to social and economic rectifications The challenge is as large as when public health was first conceived”. Kick Bush – 2005*

Source: Fran Baum, The New Public Health, Third Edition, Oxford University Press, 2008

#### 10. World Health Report : Primary Health Care : Now more than ever -2008

- “Where reforms have been successful, the endorsement of PHC by the health sector and by the political world has invariably followed on rising demand and pressure expressed by civil society”
- Thailand –Thai reformers joined a surge in civil society pressure
- “Mali –sustained extension by local community health associations”
- “Chile - agenda of democratization”
- “India – Strong pressure from civil society and the political world”
- “Bangladesh - pressure for PHC from quasi public ngo’s”
- “Countries need to demonstrate their ability to transform their health systems in line with changing challenging and rising popular expectations. That is why we need to mobilise for PHC now more than ever”

#### 11. Report of the Commission on Social Determinants of Health, 2008

The process to evolve this report included many PHM links. One of the commissioners was from PHM and in addition dialogue with CSO’s in different regions was organized by PHM. Resource persons linked to PHM participated in various knowledge hubs and finally civil society presented a report on SDH to the commission facilitated by PHM. The whole build up has been described in a peer review article mentioned below:

Source :Narayan Ravi, The role of People’s Health Movement in putting the social determinants of health on the global agenda, Health Promotion Journal of Australia, December 2006, Vol 17, No.3, Page 186 to 188, Australian Health Promotion Association.

#### 12. Social Vaccine: A new metaphor - 2009

PHM related resource persons have managed to get academia to accept the concept of social vaccines as a new metaphor to describe action on Social and Economic determinants of health. A paper has been published in Health Promotion International in 2009.

( Fran Baum, Ravi Narayan, David Sanders, Vikram Patel, and Arturo Quizhpe, Social vaccines to resist and change unhealthy social and economic structures: a useful metaphor for health promotion, Health Promotion International,2009 Vol. 24 No. 4, 428-433 )  
When you google social vaccine you reach this paper on the internet.

#### 13. Expansion of Understanding of Public Health to include the Social Determinants of Health, identified by the People’s Charter for Health.

- “the scope and reach of epidemiology, which is an integral part of public health, must be expanded to include the study of the social, cultural, economic, environmental, ecological and political determinants of health and constitute the key stone for use of evidence for development of public health policy”

Source: Proceedings of SEARO meeting on Application of Epidemiological Principles for Public Health Action WHO – SEARO , Feb 2009



14. A PhD on Social Movements in Health from SOAS used an Anthropological framework and tried to study the movement, 2010

It emphasized the presence of - different narratives – dominant and subaltern; diversity and plurality of networks & members positions on engagement with public health system, varied approaches to the engagement and convergence and divergence resulting in both clarity and conflict.

15. Recently a Global PHM Evaluation was done by a six member resource team in which a case study on India was prepared after a series of interviews and document review by a member of the team in India, 2011

This case study describes the following aspects of JSA: Evolution, perspective and objectives, structure, coordination within JSA, identity: movement or network, profiles of organisations, mobilizing participation, activities and campaign areas, major coordinated campaigns, intervention by JSA with public health, women's health, medicine's policy, right to food, communications: within and without and funding.

It identified the following achievements- visibility; many activities, campaigns and issues at national/state level; facilitating change in some states; diversity of networks & campaigns; perceived as important entity that needs strengthening,

It also identified the following challenges and recommendations (some)

- PANS process (incomplete); some states and groups unwilling to review organisational issues, and processes; need for national vision and multicentric and multisectoral mobilization; proactive communication at all levels; wider grass root mobilization; and greater transparency and accountability mechanisms

16. The PANS report which is being facilitated by SOCHARA on behalf of the PANS committee and JSA is proposed to be completed by end Dec 2011, giving a little more time for states to complete the process and for national organisations to complete the questionnaire. The report will consist of the following chapters and appendices:

1. Overview of JSA 2000-2011
2. Overview of PANS responses from National organisations.( NCC)
3. Reports of state process and meetings
4. Overview of strengths, weakness, opportunities, and challenges.
5. The task's ahead
6. Appendices
  - a) Current national /state structure/composition
  - b) Diary of key events/campaigns 2000-2011
  - c) Annotated bibliography of key JSA publications –national / state level
  - d) Any others

(Suggestions are welcome and voluntaries to help with the compilation/editorial exercise are also welcome. The draft will be widely circulated before finalization)

17. Some website links to JSA-PHM

For further information visit

[www.phmovement.org](http://www.phmovement.org) ; [www.ghwatch.org](http://www.ghwatch.org) ; [www.phmovement.org/iphu](http://www.phmovement.org/iphu) ; [www.phm-india.org](http://www.phm-india.org) ;  
[www.communityhealth.in](http://www.communityhealth.in)





## PANS Modified- Work in Progress

### Potential Sources :

#### State meetings/Processes

- ☐ Maharashtra (JAA)
- ☐ Karnataka(JAAK)
- ☐ Tamil Nadu(MNI)
- ☐ Odisha (JSA)
- ☐ Madhya Pradesh(JSA)
- ☐ Uttar Pradesh
- ☐ Delhi
- ☐ Rajasthan
- ☐ Gujarat
- ☐ Chattisgarh

#### PANS- Questionnaire(National)

- ☐ Sama
- ☐ AIDAN
- ☐ Health Watch Forum
- ☐ BPNI
- ☐ SOCHARA
- ☐ AIDWA
- ☐ CHAI

#### **individual reports on state processes**

- ☐ Renu on Maharashtra
- ☐ Sarojini on Odisha





### Reflection on Strengths – JSA (National)

- ▣ Networking Strength -local/ regional, national and international levels /the collective strength(Sama)
- ▣ Collective understanding/facilitation provides space to raise issues and concerns(AIDAN/Sama)
- ▣ The diversity of organizations and networks/different movements (SOCHARA and others)
- ▣ Collegiality of working together successfully (SOCHARA and others)
- ▣ Documentation and Publication- enabling grassroots activists to access material on issues of health
- ▣ Opportunities to build knowledge, capacity and leadership
- ▣ The analytical ability of the JSA national group/the e-group discussions which throws light on several issues (SOCHARA/BPNI)

### **Reflection on strengths- State Process**

JAA: (Maharashtra)

- ▣ Inclusive work style
- ▣ Responded positively to all national level programs
- ▣ Suggested number of programs to National JSA
- ▣ Quite instrumental in fostering CBM

JAAK: (Karnataka)

- ▣ Identity as a health rights movement
- ▣ Enhancing capacity of grass root level activists at district level
- ▣ Structure and composition reflecting collective leadership, decision making and committed individuals
- ▣ Documentation and Publication

Gujarat JSA:

- ▣ Diversity is its strength/Collective voice
- ▣ Acts as watch dog/ as a pressure creature and an bring change in the policy
- ▣ Runs without funds
- ▣ Collective strength and analysis/forum for exchange of learning
- ▣ Good image of JSA /Government is forced to ask JSA for opinion eg VHSC, PH Act





## Reflection on weakness-JSA (National)

- ▣ Very little communication reaching the individual networks regarding the activities/stands of JSA/We tend to be linguistically and regionally limited/ the sense of solidarity and communication between and across state units need to be improved (SOCHARA and others).
- ▣ Decision making- often arbitrary/ based on individual decisions- not always processes and procedures (AIDAN/Health Watch)
- ▣ Non inclusion of many who have significantly contributed to the health movement(AIDAN)
- ▣ Need for transparency (AIDAN)
- ▣ Feed backs from member networks are not taken seriously(AIDAN)
- ▣ Need to strengthen understanding/perspectives on gender, sexuality, marginalization and other emerging issues for JSA partners (Sama)
- ▣ Conflict of interest(BPNI) and diversity of opinions-therefore inadequate work on common position and common ground of action
- ▣ Weakening of the JSA collective leadership over the past few years and inadequate clarity about campaigns and support mechanism in the current global and national context. (SOCHARA)
- ▣ Younger and newer member individuals and organizations need space. Democratic forms of functioning need to be enhanced (SOCHARA)
- ▣ Not in touch adequately with likeminded movements/disability movement and mental health movement (SOCHARA)
- ▣ There is inadequate open reflection in a healthy manner (SOCHARA)
- ▣ Some organizations perceive a domination by certain groups/networks and ideologies and therefore these organizations/networks and individuals who are equity oriented have kept away and withdrawn from active participation (SOCHARA)
- ▣ The background material produced in 2000,2007and later is inadequately utilized(SOCHARA)

## Reflection on weakness-state process

- ▣ Not enough regular meetings/lack of coordination (Chattisgarh/MNI/Delhi/Gujarat and others)
- ▣ Engagement with NRHM including CBM has affected organizational work (MPJSA/Gujarat)
- ▣ Leadership deficit in the network (MNI)
- ▣ Decisions taken regarding organizational issues are yet to be implemented(MNI)





- Focus was on provision of primary health care services, hence other issues lagged behind (JAA)
- Community presence still marginal(JAAK)

#### **Gujarat JSA:**

- Lack of Publication
- Don't have strong presence in each and every district/not undertaken common activities for campaigns at the village level
- No mechanism to arrive at a common position/We have not communicated our position to the public
- Internal conflicts on rights based versus collaborative initiatives with the government

#### **Rajasthan JSA:**

- Organisations associated with JSA do not have health as a priority focus in their agenda/this makes them dormant and inactive
- Lack of resources for carrying out activities and campaigns
- Less linkages with the other state chapters/national JSA
- Irregular participation of members in meetings and activities
- Lack of participation by government officials

#### **Reflection on opportunities (National)**

- JSA emerging as a National Level Platform and PHM as a global group ( SOCHARA)
- Engagement with the public health system gained strength (SOCHARA)
- Through the civil society oriented school of public health-we look for opportunities in diverse ways that can be discussed if JSA is interested/interested to be involved with research based work of JSA(SOCHARA)
- Taking forward the campaign of health rights and health for all/designing campaigns and actions (BPNI)
- Has provided opportunities to on build knowledge, capacity and leadership of organizational members(Sama)
- Opportunities to take up campaigns and advocacy programs (CHAI)





- ▣ Collective processes (Sama) provide opportunity for-
  - a) Larger outreach
  - b) Larger impact,
  - c) Decentralised action
  - d) Wider dissemination,
  - e) Mobilisation around health issues
  - f) Influencing public opinion and policy
- ▣ Contribute to JSA analysis/ broadening the understanding (All)
- ▣ Collaborative initiatives at all levels (AIDAN/Sama)

#### Gujarat JSA:

- ▣ Community monitoring and Gujarat Public Trust
- ▣ We can use the people's health charter to mobilize people and make right to health a political issue
- ▣ Need of E-forum/opportunity for increased networking through internet
- ▣ We can combine our vision with the government aims and meet government at one common point of improving health indicators

#### Reflection on Challenges (National)

- ▣ If member groups or individuals get limited by their own analysis or develop a rigid approach to diverse ways of engagement it may lead to a weakening of the movement. Our wider social accountability needs to be kept in mind(SOCHARA)
- ▣ We have to improve the current loose coordination and improve the stability of the network(BPNI)
- ▣ Mobilization and coordination of organizations remains as a challenge (Sama)

#### Reflection on Challenges (from national and state sources)

##### JAAK (Karnataka)

- ▣ Network dynamics and administration- balance needed between democratic processes and formal structures/having full time committed persons
- ▣ Community presence- yet to evolve into a larger mass movement
- ▣ Evolving more comprehensive strategies to deal with problems in the health system (Keep Charter in mind!)





- ▣ Meeting the expectations of member networks which can be varied eg. Technical assistance, training, cultural campaigns, platform for vulnerable groups, financial support etc
- ▣ Financial and logistical support expressed by small CBO's

#### **Gujarat JSA:**

- ▣ We have not been able to educate even our friends on health rights issues
- ▣ The Gujarat Public trust act will be very restrictive for NGO's
- ▣ People in the government don't recognize the suggestions or recommendations made by the JSA
- ▣ Monitoring of private health services
- ▣ Development of anti-civil society stance among state and towards JSA
- ▣ Financial expectation of members
- ▣ What will we do with this SWOT analysis?

#### **Other sources:( All)**

- ▣ Communication and inter-linkages between national and state level activities
- ▣ Clarity on "JSA issues and campaigns"
- ▣ Mobilisation of partner organisations
- ▣ Coordination of the Network

#### **Some suggestions-National level**

- ▣ Review the decision making process (AIDAN)
- ▣ Not having involved proactively and benefitted from the tremendous experiences of Dr.Arole Dr.Antia and many others remains a deep regret as they were the pioneers of Comprehensive Primary Health Care in India (AIDAN)
- ▣ Regular national level programs need to be organised (MNI)
- ▣ Regional convener's have to be established(MNI)
- ▣ Issue based circles be tried out(professional interests/area of expertise)(MNI)
- ▣ Improve communication for sense of inclusion(AIDAN)
- ▣ Offer Capacity building for state level activists
- ▣ Mechanism need to be evolved to circulate JSA stand on many issues (to support state level campaigns/initiatives) (MNI)





- ▣ Regional level JSA meetings-easy logistics and greater participation (MNI)
- ▣ Mechanism for state units to suggest ideas for campaigns for national level response and support (MNI)
- ▣ There can be collaborative initiatives on drug issues/rational use of drugs (AIDAN)

### **Suggestions –for strengthening state level processes which are also nationally relevant**

#### Strategic issues:

- ▣ Membership need to be Strengthened/network has to expanded - identifying and involving organizations that are working in health issues
- ▣ Work done by various organizations need to be shared(Chattisgrah)
- ▣ Advocacy efforts as JSA need to be undertaken in the state (Chattisgrah)
- ▣ Invite new networks involving agricultural issues/ dalit issues/women issues
- ▣ Strategies need to be worked out about how CBM process can be strengthened to support movement(Maharashtra)
- ▣ Simplify and popularize the health charter (Maharashtra)
- ▣ Ensure centrality of community by starting at the grass root level
- ▣ Redressal strategies to be strengthened: lobbying for legal compensations cases of health denials
- ▣ Mobilizing information through RTI/becoming state level pressure group
- ▣ Each member networks have specific strengths, these strengths need to be taken into account while planning
- ▣ District level JSA chapters and units should be created across the state (Rajasthan)
- ▣ Role of civil society organizations in planning and formulation of schemes need to be recognized by the government
- ▣ More visits and interactions with other JSA state chapters should be promoted(Rajasthan)
- ▣ Dialogue with the govt. should be increased/representation of govt. officials in JSA meetings and activities should be enhanced (Rajasthan)





### Form, structure and capacity building:

- ▣ Collective leadership: The present structure of a convenor, co-convenor and secretariat needs to be revamped to bring in collective leadership
- ▣ There is a need to re-look at the state level structure and explore options/the possibility of a state coordination group that comprises representation from diverse organizations(Delhi)
- ▣ Build the capacities of the people involved (Chattisgarh)
- ▣ Create forum where the representatives at the zilla level are represented at the state level
- ▣ It is necessary to have a proper structure for JSA and an action plan to get things on track(Chattisgarh)
- ▣ Have an organisation /office structure and health activists at the zilla level
- ▣ Training in using technology for better communication, documentation, research and advocacy
- ▣ Immediate helpline for the health workers/activists
- ▣ Encourage/ train health activists/JSA members in health action and movements and promote exposure visit/ learning

### Building linkages with other movements/campaigns/Individuals:

- ▣ Building strategic and working linkages/enhanced support, collective action and improved outcomes of our action using charter as frameworks
- ▣ Involve younger activists/PRI/other movements/ likeminded people, intellectuals and other stake holders

### Strengthen content of movement initiatives:

- ▣ A holistic and comprehensive method to look at the social determinants of health-employment, food security, housing, water, education and other issues as identified in the charter





### Human Resources:

- ▣ Should we have full time activists at district and state level..?
- ▣ Should we set up a media intervention circle for JSA at national and state level..?

### **From individual reports on state processes:**

#### **Renu on Maharashtra:**

- ▣ Lateral relationships between state JSA's should also be recognized e.g. Gujarat and Maharashtra on the Gujarat Public Health Act etc.
- ▣ Need to Share more between states, share resources and exchange visits

#### **Sarojini on Odisha:**

- ▣ There is a need to involve more women and women groups and women participants in JSA
- ▣ There is a need to build the capacities of partner groups/need to build the capacity on larger determinants of health
- ▣ There is a need to build second level leadership within the JSA Orissa
- ▣ Not every state is equipped rather has the privilege to circulate/share through internet. Hence we need to establish a mechanism for better communication
- ▣ We also need to rethink about the role of national convenor and joint convenors if they are not contributing to the state processes





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# JSA - PANS (Participatory Assessment of Network Strengthening)

Brief protocol for member organizations / networks of the National Coordination  
Committee of JSA

Name of the organization / network : .....

1. When did your organization / network **link** with JSA and **join** the NCC? (please give brief history including when, why, how and who were the key representatives of your organization participating in the NCC from 2000 to date)

2. What has participating in the JSA meant for your organisation? (state upto three **opportunities** in general and all collaborative initiatives in particular)

3. What has been the **contribution** of your organisation/network to JSA? (mention all the contributions including participating in national events / initiatives and contributing reports / publications / educational materials / advocacy materials / research reports / representing JSA in other regional / national / international events / contribution to governance etc.,)

4. From your organizational / network experience what do you think have been the main **strengths** in relationships / experience with JSA?





5. From your organizational / network experience what do you think have been the main **weaknesses** / obstacles in relationship / experience with JSA? Any suggestions of how they could have been overcome / should be overcome?
6. What **opportunities** do you see for your organisation and the JSA for collaborative functioning in the coming period?
7. Are there any observations / suggestions that could mention as problems / **challenges** that could continue to affect JSA's efforts to strengthen itself?
8. Does your organization / network have members that work with JSA at the state level - if so which states?





9. Are there any issues your organisation has encountered in getting involved in state level activities?
10. Are there any other possibilities / **opportunities** of collaborative **initiatives** /collaborative **campaigning** that can be taken forward by JSA and your organisation? Give examples?
11. Any other matter about JSA – national and state level and above NCC which you would like to raise as part of the PANS exercise?

12. List out as much of the following to supplement the information at the secretariat level. **(You may use separate sheet if required:**

- a. List of key organizations / networks in the state coordination committee as of 1<sup>st</sup> October 2011 (include list of office bearers and committees if any)
- b. List of events in the last two years - 2010 / 2011 (including engagement / dialogue with state government, campaigns, struggles, community action etc)
- c. List of publications in the last decade – 2001 – 2011 (of significance to JSA)
- d. List of translations in the state vernacular of international PHM / national JSA documents and publications
- e. List of key individuals who have represented your organizations / networks in JSA / NCC since 2001
- f. Any other information / publication / campaign materials that you would like to send to the PANS committee / secretariat

Name of respondent from organization / network  
(to be contacted by PANS committee for  
further information if required

Date :

\*\*\*\*\*









